Plaintiff PEC Cross-Notice of Remote Deposition and Non-Retained Expert Witness Disclosure of Dr. Rahul Gupta

Exhibit 3

Gupta Deposition
April 15, 2021

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

* *

THE CITY OF HUNTINGTON,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01362

AMERISOURCEBERGEN DRUG CORPORATION, et al.,

Defendants.

_____

CABELL COUNTY COMMISSION,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01665

AMERISOURCEBERGEN DRUG CORPORATION, et al.,

Defendants.

* *

Videotaped and videoconference deposition of RAHUL GUPTA, M.D. taken by the Defendants under the Federal Rules of Civil Procedure in the above-entitled action, pursuant to notice, before Teresa S. Evans, a Registered Merit Reporter, all parties located remotely, on the 15th day of April, 2021.

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P R O C E E D I N G S

VIDEO OPERATOR: Good morning. We're going on the record at 11:33 a.m. on April 15th, 2021. Please note that the microphones are sensitive and may pick up whispering, private conversations and cellular interference.

Please turn off all cell phones or place them away from the microphones as they can interfere with the deposition audio.

Audio and video recording will continue to take place unless all parties agree to go off the record.

This is Media Unit 1 of the video recorded deposition of Rahul Gupta, M.D., taken by Counsel for the Defendant in the matter of City of Huntington versus AmerisourceBergen Drug Corporation, et al and Cabell County Commission versus AmerisourceBergen Drug Corporation, et al, being filed in the United States District Court for the Southern District of West Virginia, Case Nos. 3:17-01362 and 3:17-01665.

This deposition is being conducted remotely via Zoom conferencing. My name is Adam Hager from the firm Veritext; I'm the videographer.

The court reporter is Teresa Evans from the firm Veritext.

I am not authorized to administer an oath; I am not related to any party in this action; nor am I financially interested in the outcome.

Counsel and all present in the room and everyone attending remotely will now state their appearances and affiliations for the record.

If there are any objections to proceeding, please state them at the time of your appearance, beginning with the noticing attorney.

MS. MAINIGI: Good afternoon. This is Enu Mainigi from Williams & Connolly for Cardinal Health.

MR. RUBY: And Steve Ruby also for Cardinal Health.

MR. HESTER: This is Timothy Hester from Covington & Burling representing McKesson Corporation.

MS. CALLAS: Gretchen --

MR. BAILEY: This is -- sorry. Clayton Bailey also from Covington & Burling, for McKesson.

MS. CALLAS: Gretchen Callas for

AmerisourceBergen.

MS. KEARSE: Anne Kearse on behalf of the Plaintiffs.

MR. MAJESTRO: Anthony Majestro on behalf of the Plaintiffs.

MR. FARRELL: Paul Farrell on behalf of the plaintiffs.

MR. COLANTONIO: Mark Colantonio, Bob Fitzsimmons, representing Doctor Gupta for purposes of this deposition.

MR. SHKOLNIK: Hunter Shkolnik also representing Doctor Gupta for the purposes of this deposition.

VIDEO OPERATOR: If there are no further appearances to be noted, would the court reporter please swear the witness.

(The witness was sworn.)

R A H U L G U P T A , M. D. ,

was called as a witness by the Defendants, and having been first duly sworn, testified as follows:

EXAMINATION

BY MS. MAINIGI:

Q. Good afternoon, or good morning, Doctor Gupta. How are you today?

A. Good morning. I am well, thank you. And how are you?

Q. I'm good, thank you. We met off the record, but just I'll state it again. My name is Enu Mainigi, and I represent Cardinal Health, and I'm going to be doing the questioning today.

Before we get started, Doctor Gupta, you are -- where are you doing this deposition from?

A. I'm doing this deposition from Pentagon City.

Q. And at a particular office? Whose office?

A. This is the Ritz Carlton at Pentagon City.

Q. And who is in the room with you, Doctor Gupta?

A. Mark Colantonio and Bob Fitzsimmons.

Q. And those are the only individuals in the room with you?

A. Yes.

Q. And besides the exhibits that your attorneys may have received from us to have handy for you, do you have any other documents in front of you?

A. No.

Q. Do you have any notes in front of you?
A. No.
Q. Doctor Gupta, you were deposed in this case last September. Do you understand why we are here doing another deposition?
A. I do have a fair amount of understanding.
Q. Could you explain to me what your understanding is?
A. My understanding is that you want to talk to me to see if there's another -- more areas within the context of the previous deposition that I can help with.
Q. Are your -- are you aware, Doctor Gupta, that counsel for Cabell and Huntington submitted a supplementary disclosure regarding potential expert opinions that you might offer at trial?
A. I'm not aware.
Q. Could you put --
MS. MAINIGI: Bob, are you going to be the one assisting with exhibits?
MR. COLANTONIO: Well, we don't have -- we didn't print out the actual exhibits here. I have them on e-mail, but we don't -- so I just kind of prefer -- this is Mark speaking, by the way.

You put them up on the -- for the doctor to see and then he can comment on them.

But we don't have printouts right here of all the exhibits.

MS. MAINIGI: Okay. Steve, are you --

MR. RUBY: I thought -- sorry, Mark, I thought you guys were going to have them printed for -- for doctor Gupta.

MR. COLANTONIO: Yeah, I apologize if that was a -- I didn't -- I just don't have them here, Steve. But I think -- I think if you put them up that he'll be able to, you know, do it that way.

MR. RUBY: Well, let's do this. Let me --

MS. KEARSE: Yeah, Steve, I thought you were doing them remotely as well. We just -- and we didn't get copies of them.

MR. RUBY: Hold on. Let me --

MS. MAINIGI: Well, while -- while we gather up some of the exhibits, I think, Steve, we'd want to -- I'm not even sure we need 51, but I guess 58 would be one of the next ones.

BY MS. MAINIGI:

Q. So Doctor Gupta, let's just go ahead and jump in. Is it correct that you worked in West Virginia from approximately 2009 to 2017?

A. That is correct, but that is not the entirety of my experience in West Virginia.

Q. What other experience did you have in West Virginia beyond -- beyond the experience of those years?

A. I had worked in West Virginia from March of 2009 to November of 2018. And after that, I continued to be a volunteer physician to date with West Virginia Health Right, which is a charitable clinic in Charleston, West Virginia.

Q. And is that something you do through today, Doctor Gupta?

A. Yes.

Q. And how often do you volunteer as a physician at that clinic?

A. I would take advantage of every time I'm able to or most times I'm able to visit West Virginia, to be able to do that. That could be ranging anywhere from once a month to once every few months.

Q. And that has happened since your departure

from West Virginia in approximately November of 2018. Is that correct?

A. I have volunteered in my time since my departure from West Virginia in November of 2018.

Q. And your present position, Doctor Gupta, is being the chief medical officer at the March of Dimes; is that correct?

A. My current position at March of Dimes is chief medical and health officer, as well as the interim chief science officer, and senior vice president --

Q. I'm sorry, you cut out there, Doctor. Senior vice president of what?

A. Of March of Dimes.

Q. Did you take the role at the March of Dimes beginning in approximately 2018?

A. Yes.

Q. And you moved to the Washington, D.C. area around that time?

A. I did not move immediately to the Washington area.

Q. Did you commute for some period of time?

A. Yes.

Q. When did you move to the Washington, D.C.

area?

A. Probably around February or March of 2019.

Q. Doctor Gupta, the March of Dimes is a global organization focused on maternal and infant health; is that correct?

A. Yes.

Q. And the March of Dimes works on prenatal education, among other things. Is that correct?

A. That would be part of the work that we do at March of Dimes.

Q. And also professional education?

A. That would be accurate as well.

Q. And also NICU support and resources?

A. That would also be accurate, NICU standing for neonatal ICU.

Q. Thank you. And also health equity, Doctor Gupta?

A. That would also be correct.

Q. And a fairly extensive medical research agenda? Is that correct also?

A. That would be correct.

Q. And the work that the March of Dimes does, that's done on a global basis, true?

A. The work of March of Dimes historically and

currently is done both at domestic levels as well as international level.

Q. Now, while at the March of Dimes, Doctor Gupta, you are not acting as a specialist in addiction treatment, correct?

A. That would be correct.

Q. You're not acting as a specialist in pain management, correct?

A. That would be correct.

Q. You're not a specialist in neurobiology, correct?

A. Could you please repeat that last one?

Q. Sure. You are not acting as a specialist in neuro -- neurobiology, correct?

A. Could you please explain? I'm not -- no, I mean, I don't understand the question about a specialist in neurobiology. There's no - to my knowledge - a physician position of being a specialist in neurobiology.

Q. Okay. Thank you. And you're not acting as a specialist at the March of Dimes in epidemiology, correct?

A. That would be incorrect.

Q. That would be incorrect?

A. That's correct.
Q. Okay. Could you explain to me how you are -- what your role is as a specialist in epidemiology at the March of Dimes?
A. My work that includes the title of the chief medical and health officer as well as the chief science officer often involves the engagement of the principles of epidemiology, biostatistics, policy, which are all part of my training as well as my experience and expertise.
Q. Do you act as a specialist in epidemiology in -- at the March of Dimes, Doctor Gupta? Or do you interact with epidemiologists?
A. I am the person that is in charge and not only in charge of other epidemiologists, but I am the person that other epidemiologists look to for expert advice.
Q. And do other epidemiologists look to you for epidemiology advice?
A. That's correct.
Q. In what areas, please?
A. In areas of epidemiology.
Q. And can you give me specific areas, please?
A. Areas of maternal health, infant health,

population health, health policy, biostatistics. I can go on.

Q. Do you have any training in epidemiology, Doctor Gupta?

A. I have both training and experience.

Q. Do you have -- let me ask this first: Do you have any formal training in epidemiology?

A. Yes.

Q. What is the formal training you have in epidemiology?

A. Beyond my medical degree where I had extensive training in public health and epidemiological practices of five and a half years, I have a master's in public health from University of Alabama-Birmingham.

Q. Have you ever held yourself out as an epidemiologist when you were practicing medicine, Doctor Gupta?

A. I do not understand the nature of the question. Could you please rephrase?

Q. Sure. You have a -- you have training in internal medicine, correct?

A. Correct.

Q. And I -- as I understand it, for some

period of time, you were in private practice and you held yourself out as an internist. Correct?

A. Amongst other areas as well, correct.

Q. And my question to you then, with that background, is: Have you ever held yourself out as an epidemiologist and solely an epidemiologist?

A. I still do not understand the nature of the question of being a physician solely as an epidemiologist. I can help to answer the question this way: That as the local health officer and physician director, which is the official position at Kanawha-Charleston Health Department, my role from March of 2009 to December of 2014 - which was almost six years - involved leading a team of epidemiologists in a variety of work that included conducting epidemiological surveys, studies, analysis and policy making as a result of that work for the largest county in the state of West Virginia, which is Kanawha County.

Following that, because partly of that work, the Governor of the state of West Virginia asked me to serve as the State Health Officer, which also requires to have - similar to Kanawha-Charleston Health Department - a

significant experience and expertise in epidemiology in order to serve in that position.

So both of those positions, from March of 2009 to November of 2018, required significant expertise in epidemiology as -- as per stated in statute for the State of West Virginia and the policies of Kanawha Charleston Health Department.

Q. Okay. We'll come back to that time period.

MR. RUBY: Enu, not to interrupt, but we are set up to screen share the exhibits whenever you want.

MS. MAINIGI: Oh, terrific.

Q. Speaking of West Virginia, when you were in West Virginia, did you ever live in Huntington?

A. No.

Q. Did you ever live in Cabell County?

A. No.

Q. Did you ever work in Huntington?

A. Yes.

Q. And when -- from when to when did you work in Huntington?

A. My work as the health commissioner for the State and the State Health Officer required me to ensure that my work involved not just in Kanawha

County, but for all 55 counties and all the cities within the jurisdiction of the State of West Virginia.

That work involved a number of activities, including visits, as well as epidemiological work, investigatory work, regulatory work, as well as other facets that included Cabell County as well as the City of Huntington.

And part of my job was to not only work with the public health department, but also the elected and other officials from Cabell County and the City of Huntington.

Q. How often do you think while you were in that role, Doctor Gupta, that you visited Huntington or Cabell County?

A. Could you please define the time period?

Q. The time period that you were State commissioner.

A. I would visit the City of Huntington and Cabell County, broadly speaking, anywhere from, you know, once every couple of weeks to once every couple of months.

Q. Were -- was there a system at the

Commission of keeping track of where you traveled? Was there a log or something that was maintained?

A. I'm sorry, which commission?

Q. Well, let's see. You became the State -- you're speaking about the State health commission, correct? In that role as the State Health Officer, you visited Cabell and Huntington. Right?

A. No, Ms. Mainigi, I was the Commissioner of the Bureau of Public Health at the West Virginia Department of Health and Human Resources, which is -- also provides the -- by statute, the position of the State Health Officer, so I'll just step back a little bit and help to -- help --

Q. That's okay. I -- not to interrupt you, but thank you for that clarification. So let me just keep going. While you were the Commissioner of public health, that's when you made somewhat periodic visits to Cabell and Huntington, correct?

A. That is not the only time.

Q. Okay. Well, let's stick with the time you were in that role. You mentioned that you ranged from one time every couple of weeks to one time every couple of months, correct?

A. Yes.

Q. And my question to you, sir, is: Is there a log that was maintained of the various places you visited, including Cabell and Huntington?

A. There were a lot of visits. I think you would have to ask the Department of Health and Human Resources about the policies of keeping those type logs. I would not be the right person for that.

Q. And then you wanted to tell me about another time, or in another job that you visited Cabell and Huntington, right? What role was that that you helped?

A. Sure. That was the role of being the physician director and local health officer for the largest county in the state of West Virginia, and one of the largest other counties was Cabell County and the City of Huntington.

So what that meant was it was critical that we -- the two health officers were the only two full-time health officers that were local health officers in the State of West Virginia, so it was essential for us to have a very close relationship and understand what is happening in each of our counties.

That required a lot of traveling back and forth, both for the local health officer of Cabell-Huntington Health Department as well as that of Kanawha-Charleston Health Department.

Q. Okay. So just to clarify, you were the executive director of the Kanawha-Charleston Health Department, correct?

A. Executive director and physician health officer.

Q. Okay. And there was someone else that was in the role of the Cabell-Huntington Health Department head, correct?

A. Right.

Q. And who was that person?

A. Currently, it's --

Q. Well, let me interrupt you. While you were -- and I apologize for that.

MS. KEARSE: I guess, Enu, if he's -- let him finish answering your question --

MS. MAINIGI: Okay. I don't think he was actually --

Q. My question was unclear, actually, Doctor Gupta. Let me clarify, if you don't mind, my question.

At the time you were head of Kanawha-Charleston, who was, to your recollection, the head of Cabell?

A. The current health officer, Doctor Michael Kilkenny, and the prior health officer, prior -- the predecessor of Doctor Kilkenny, those were the two health officers I primarily dealt with.

Q. Thank you.

A. And it may have been that -- I don't remember exactly when Doctor Kilkenny was hired, so I -- you know, it's been a while, so excuse me for not remembering exact dates.

Q. No problem, Doctor Gupta. Now, Dr. Gupta, as I understand it, you right now are under consider -- under consideration to be drug czar of the United States?

A. Is there a question there?

Q. Yes. That's the question. Are you under consideration to be drug czar?

A. Well, I think the reports in the media that have reached out to me and others, I have -- I will provide you the same answer as I have to them, which is I don't have anything to say about that right now.

Q. Are you currently being vetted for that position?

A. I don't have anything to say about matters that do not pertain to this particular deposition.

Q. Well, Doctor Gupta, with all due respect to you, I do think you've got to answer the question. Let me work a little bit backwards and maybe you'll understand --

MS. KEARSE: And Enu, I understand --

MS. MAINIGI: Hang on. Let me finish, and you can object to the next question if you want to, but Anne, I don't need any speaking objections.

MS. KEARSE: I didn't even get to say anything, Enu.

BY MS. MAINIGI:

Q. Doctor Gupta, are you intending to testify at the trial in this matter?

A. Yes.

Q. And are you expecting to testify in person at the trial in this matter?

A. Yes.

Q. How does the timing -- to your knowledge, how does the timing of your possible nomination to this role of drug czar relate to your testimony in

this matter, with this matter beginning trial on May 3rd?

MR. COLANTONIO: You're asking him as to his physical appearance at trial, right?

MS. MAINIGI: Correct.

A. Ms. Mainigi, you are speculating at this point and which I prefer not to answer and not to give -- not to speculate answers for.

Q. Okay. That did not, Doctor Gupta, answer my question. If you were -- let me ask it this way and perhaps that will help you.

MR. COLANTONIO: Enu, can I help?

MS. MAINIGI: No. No, thank you.

MR. COLANTONIO: All right.

Q. If you are nominated to be drug czar, will you testify still at the trial in this matter that begins on May 3rd?

MS. KEARSE: Objection, calls for speculation.

A. Ms. Mainigi, I just cannot -- sitting here today, I'm trying to help to determine the facts of the -- of your questioning and the line of questioning. The judge has asked me to do that, and I'm happy to do that. But I can't answer any

speculative questions at this point.

Q. Doctor Gupta, if you are confirmed as drug czar, will you testify in this matter?

MS. KEARSE: Objection.

A. My answers remain the same.

Q. Doctor Gupta, what is the current status of your application to be drug czar?

MS. KEARSE: Objection.

A. My answers are already said. Asked and answered.

MS. KEARSE: And Enu, this is Anne Kearse again. This is a targeted -- this is a targeted deposition that the judge ordered, so I think we should stick to the order and proceed with the questions that -- outside of this area of testimony.

MS. MAINIGI: Thank you, Anne, but I'm sure Doctor Gupta can answer these questions for himself.

Q. Doctor Gupta, you did not answer -- you did not answer my question.

MS. MAINIGI: Could I have my question read back, please?

COURT REPORTER: Sure.

(The question was read by the court reporter.)

A. Doctor Gupta, please answer that question.

MS. KEARSE: Objection. And I have a standing objection to this line of questioning.

A. I don't know.

Q. You mentioned that the judge had asked for your help in this matter. What is your understanding of the help that the judge has asked for?

A. As I stated prior, I'll repeat my answer again, which is that my understanding of this deposition is that you would like to know more into the depth of my prior deposition, which I'm happy to be here voluntarily and provide that information to you.

Q. You were deposed in September, correct, Doctor Gupta?

A. To my recollection, yes.

Q. At that time, had -- to your recollection, had your name been suggested by anyone that you're aware of for the role of drug czar?

A. I don't know.

Q. Just circling back a little bit on your

background -- further on your background, Doctor -- Doctor Gupta, you have a one-year undergraduate degree and a medical degree from the University of Delhi, correct?

A. Not correct.

Q. What is not correct about that?

A. I don't have a one-year degree, undergraduate degree.

Q. You have an undergraduate degree from the University of Delhi, correct?

A. Incorrect.

Q. Okay. What is the -- what are the degrees you have from the University of Delhi?

A. I have master's of -- excuse me. Bachelor's of medicine and bachelor's of surgery degree. I have diploma in tuberculosis and chest diseases.

Q. You have an undergraduate degree from the University of Delhi.

A. Is that a question?

Q. Yes.

A. I have -- I do not have a degree, one-year degree, from the University of Delhi.

Q. Do you have an undergraduate degree from

the University of Delhi?

A. I do not have an undergraduate degree from the University of Delhi.

Q. Okay. And I think you referred to this already, but after your medical degree, did you -- you received specialized training in tuberculosis and chest diseases? Is that correct?

A. That's correct.

Q. And then you received a master's -- do you have a -- let me just come back to your undergraduate degree. Do you have a bachelor of science from the University of Delhi?

A. I do not.

Q. You do not have a bachelor of science degree from the University of Delhi.

A. I do not have a bachelor of science degree from the University of Delhi.

Q. So if we -- if you testified to that previously, was that incorrect?

A. I would have to look at my testimony previously to determine that.

Q. Okay. You have a master's in public health from the University of Alabama at Birmingham?

A. That's correct.

Q. And then you have an M.B.A. that you obtained through UNINETTUNO University; is that correct?

A. I'm sorry, could you repeat that?

Q. Do you have an M.B.A.?

A. Yes.

Q. And where is that from?

A. That's the London School of Business and Finance.

Q. And what degree, if any, do you have from UNINETTUNO University?

A. I think it's the same one. They -- there's -- it's the London School of Business And Finance. This is the other name for that, or that's one of the issuing degrees; the other is where you go to school. That's -- I think that's the confusion you may--

Q. Did you go to school in London or was it an online program?

A. Mostly online program.

Q. And was that online program based in Italy?

A. There were some optional classes to be able to attend in Italy as well as in London.

Q. Now, you were in private medical practice

for four years in Alabama; is that right?

A. If you -- it would be helpful if you gave me the years so I can -- because there were several others in that time as well.

Q. I was hoping you'd have your CV printed out, but that's not the case. So I don't know the years off the top of my head, but did you practice --

Let me go ahead and pull up your CV.

MR. RUBY: Enu, I can put this on the screen share if it's helpful.

MS. MAINIGI: That would be terrific.

Q. I don't think it's a controversial fact here, Doctor Gupta, but --

MR. RUBY: And just --

Q. -- your CV reflected you were in private medical practice for four years?

MR. RUBY: Just administratively, I'll note that this was Exhibit 51 from the September 2020 deposition of Doctor Gupta in this case.

A. So if you're referring, Ms. Mainigi, to primary care physician, Florala Medical Clinic, 2000 to 2004, that's accurate.

Q. Okay, thank you. And as a primary care

physician, you dealt with whatever problems walked in the door. Correct?

A. I had a clinical practice, outpatient practice. I also functioned as an emergency room physician for the local hospital, and in that sense, for both of those positions, I did have to deal with, in a rural underserved area, to a variety of patients and a variety of needs.

Q. And then you became -- after that point, Doctor Gupta, you became a practicing faculty member at the University of Alabama-Birmingham; is that right?

A. That's correct.

Q. And there you also specialized in internal medicine, correct?

A. I specialized in internal medicine, primary care, as well as hospitalist.

Q. And it was after that time period that you became the executive director of the Kanawha-Charleston Health Department in West Virginia; is that correct?

A. I think you skipped the -- my tenure in Nashville. But at some point, it is correct that after that, technically, I became -- I moved to

West Virginia, but not before taking a route through Nashville.

Q. Ah, I'm sorry about that. Thank you for adding that in. In Nashville, you also specialized in internal medicine; is that right?

A. I was internist. I was also a hospitalist. I was also a primary care physician and an academic physician both at Meharry Medical College and Vanderbilt University Medical School in Nashville, both in Tennessee.

Q. And then when you became the executive director of the Kanawha-Charleston Health Department, that was in approximately 2009? Is that correct?

A. That is correct.

Q. And the role that you held there as executive director of the Kanawha-Charleston Health Department, that role covered a wide range of duties; is that right?

A. That would be right, accurate.

Q. And so just -- I want to just run through the areas of coverage, if I could, Doctor Gupta. As I understand it from some of the materials we've read, some of the areas of coverage for that role

included diabetes, for example? Is that right?
A. That would be correct.
Q. Obesity, correct?
A. That would be correct.
Q. Heart disease?
A. Correct.
Q. I think you also set up a school or helped to set up a School of Public Health at West Virginia University while in role, correct?
A. That would be correct.
Q. And you ran a program to respond to the three chronic health problems of obesity, diabetes and heart disease, correct?
A. Amongst other things, yes, that is correct.
Q. And you set up the State minority affairs office, correct?
A. I helped in the legislation passage for the Governor's cabinet office of minority affairs.
Q. And did you help to set up a pulmonary rehab project while executive director?
A. I supported the setup of that as well.
Q. Did you also work on Medicaid expansion under ACA while executive director?
A. I successfully helped persuade then-

Governor Tomblin to expand Medicaid as part of the Affordable Care Act in West Virginia.

Q. You also, while executive director, responded to a major water contamination event, correct?

A. Right.

Q. And your agency was responsible for inspecting restaurants, correct?

A. Correct. In -- within the confines of the jurisdiction of Kanawha County, including the City of Charleston.

Q. And your agency was also responsible for indoor air quality, correct?

A. Correct.

Q. Also responsible for immunizations, correct?

A. That would be accurate.

Q. Also responsible for tuberculosis, correct?

A. Responsible for surveillance of tuberculosis, case management, case investigation as well as provide -- helping ensuring treatment for those cases which were made, as well as the work.

Q. In your role as executive director, your

agency was also responsible for lice treatment and counseling, correct?

A. The department would be responsible for ensuring all the public health activities and the confines of which included ensuring safe schools, which often also included, amongst other things, making sure that there was enough of treatments available for lice.

Q. And on top of those responsibilities, you also had responsibility for day-to-day management of the health department, correct?

A. That would be correct.

Q. And probably some other areas that we haven't discussed. Correct?

A. That would be accurate.

Q. Now, while you were at -- while you were executive director of Kanawha-Charleston, the Health Department, did you act as a specialist in addiction treatment?

A. No.

Q. Did you act as a specialist in pain management?

A. No.

Q. Did you act as a specialist in

neurobiology?

A. Once again, I'm not aware of particular licensing around neurobiology physicians.

Q. And once again, you would say, Doctor Gupta, that you did act as a specialist in epidemiology while you were executive director; is that right?

A. That would be accurate.

Q. And do you have any licensing in epidemiology?

A. I'm -- I'm not sure -- which particular licensing are you asking about?

Q. Well, to your knowledge, is there licensing that exists for epidemiology?

A. I am not aware of a physician specialty through the Board of Medicine that is exclusive for epidemiologists' practice.

Q. So you're not aware of any licensing related to epidemiology.

A. I'm not aware of any specialist licensing in the medical practice of West Virginia that provides that type of licensing.

Q. Okay. And what about outside of West Virginia? Are you aware of any medical

organizations that license in epidemiology?

A. I would not be aware at this time of any particular organizations. Knowing that the practice of medicine is regulated by State Board of Medicine, not outside organizations, in the State of West Virginia.

Q. Now, in 2014, you became the State Health Officer for West Virginia, correct?

A. I'm sorry, could you repeat that, please?

Q. In 2014, you assumed the role of the State Health Officer for West Virginia?

A. That would be incorrect.

Q. Tell me how it's incorrect.

A. I assumed the role in January of 2015 of commissioner for the Bureau of Public Health at DHHR and the State Health Officer.

Q. Let me just go back to the epidemiology point. Are you aware of an organization called the American College of Epidemiology?

A. Not -- that doesn't sound like an organization that I have worked with.

Q. So if you haven't heard of it, you're not a member of it, I assume.

A. I don't think I'm a member of it.

Q. Now, your role that you assumed in January of 2015 as the State Health Officer for West Virginia, I assume that had a wider range of duties than the duties you had at Kanawha Charleston, correct?

A. That would be accurate.

Q. And so as the State Health Officer, as I understand it, you oversaw more than 130 separate programs; is that right?

A. That would be accurate, and just wanted to add so -- in case -- I know you probably didn't mean to miss this out on purpose, but during that time, I was also the health officer and physician director for Putnam County Health Department as well, part of the time that I was in Kanawha County.

That's -- and by the way, just to -- for your knowledge, that's the connection county between Cabell and Kanawha. You have to drive through Putnam County to get to Cabell.

So during that time also - going back to your previous question - I was in the most contiguous county next to Cabell and the City of Huntington, and that was another level of

importance that we had to coordinate our work with Cabell County.

So these three contiguous counties linked with each other, and it was critical that we worked together.

Q. Thank you. Coming back to your role as State Health Officer, Doctor Gupta, you had a budget of about $270,000,000; is that right?

A. That was my direct responsibility. I also had some indirect responsibilities as well.

Q. But your budget, your direct responsibility budget, was about $270,000,000?

A. That would be accurate.

Q. Okay. And you had about 500 plus employees, correct?

A. That would be correct.

Q. And you oversaw the State's EMS system; is that correct?

A. That is also.

Q. And in terms of areas that you worked on, do some of the areas include - let me go through a list with you like we did before - community paramedicine? Accurate?

A. Yes. That was one particular program that

I was the architect of.

Q. Okay. Environmental health? Is that accurately a duty of yours?

A. I oversaw the Office of Environmental Health Services.

Q. And again, immunizations? Did you oversee immunizations?

A. I did oversee the Office of Immunization Services.

Q. Did you oversee any sort of program related to the health effects of surface coal mining?

A. I don't remember if there was any program that you mentioned.

Q. Did you oversee flood response?

A. I'm sorry, could you repeat that?

Q. Yes. Did you oversee flood response?

A. As the State Health Commissioner, there were portions of the flood response that we oversaw working very closely with the other first responders at state and local levels.

Q. How about the Office of Laboratory Services? Did you oversee that office?

A. Yes.

Q. Did you oversee bioterrorism preparedness?

A. Yes.
Q. Did you oversee any Zika outbreaks?
A. I did oversee the planning for Zika as well as the action plan and other activities related to the -- to the Zika outbreak.
Q. And I assume you had to develop a plan, a Strategic Plan, for the whole Department of Health and Human Resources while you were the State Health Officer?
A. Yes, I assisted in that as well.
Q. Were you also the secretary of the West Virginia Board of Medicine?
A. Yes.
Q. And were you involved in medical licensing and discipline?
A. Yes.
Q. And did you have day-to-day management for the Bureau of Public Health?
A. Could you repeat that, please?
Q. Sure. Did you have day-to-day management of the Bureau for Public Health?
A. Yes.
Q. And I assume there are other areas that weren't specifically highlighted in your resume

that you covered as the State Health Officer. Is that fair?

A. Yeah, along with these areas that you mentioned, all of which required epidemiological expertise. There are some other areas as well that required epidemiological expertise in leadership, yes.

Q. Now, you had mentioned earlier your work -- well, actually, let me start over. While you were the State Health Officer, did you also work time as a practicing physician in a volunteer capacity?

A. While I was the State Health Officer, I took personal time off to volunteer in my community on a personal level at the charity clinic West Virginia Health Right, and have been doing that since 2009.

Q. It's the same clinic that you've been volunteering at since 2009?

A. Yes.

Q. And you volunteer at that clinic as a general practitioner; is that right?

A. Primary care practitioner, an internist.

Q. Now, Doctor Gupta, you've been retained as an expert consultant in opioid litigation in West

Virginia, correct?

A. I am not sure which -- there's multiple -- so if you could help me understand which particular litigation you're --

Q. Sure. You -- the counsel that you're sitting with, as well as Mr. Shkolnik who's on video, you've been retained by them as an expert consultant in opioid litigation in West Virginia, correct?

A. Yes.

Q. And that's a different set of cases than the case that you're testifying in here today, correct? Do you understand that?

A. I don't -- I don't know exactly, but -- I don't know exactly what the set of those cases versus these cases are. I understand that -- that I'm here testifying as a result of being asked to testify.

Q. And the work that you're doing as an expert, you're paid for that work, correct?

A. Which is not this case. The other case, yes.

Q. Okay. So you do understand you're not a paid expert in this case, correct?

A. Correct.
Q. Okay. The other case where you are a paid expert, what's the rate at which you're paid?
A. I actually don't remember. I will be happy to get that to you.
Q. Okay. Does $500.00 an hour, does that ring a bell?
A. That would be somewhere close to it, the range.
Q. And is that engagement still in effect today? Meaning you're a paid expert consultant in that other case?
A. Yes.
Q. And that paid engagement was in effect, I think, in September 2020 when you last testified, correct?
A. Correct.
Q. Now, do you remember giving an opioid -- a deposition in an opioid case back in about 2016?
A. I do remember, yes.
Q. And you were not a paid expert consultant in 2016, correct?
A. Correct.
Q. Do you remember approximately what time

period you became a paid expert consultant?

A. At this point, I can only guess as somewhere in 2019.

Q. And when you were first approached to be a paid expert consultant, was it on the topic of abatement?

A. Yes.

Q. Since that time, has your work expanded to cover other areas besides abatement?

A. No.

Q. So you remain a paid expert consultant in the area of abatement; is that right?

A. Yes.

Q. And how do you define "abatement"?

A. Abatement is all those strategies that would help to address the problem that we're facing today.

Q. So give me some examples.

A. Examples would be to figure out how to treat -- have a system of treatment, system of response, a system of where people can be addressed with their first nonfatal overdose so they don't die eventually. We could put in measures that could prevent the spread of HIV and Hepatitis

that's killing West Virginians today and causing much more difficult problems in their lives.

Education would be important as well. And making sure that fewer pregnant women are -- or pregnant women are connected -- being connected to treatment during pregnancy or having fewer babies with NAS as a result.

So all of those strategies that would help us address the problem we're facing today in the state of West Virginia.

Q. And just to be clear, you are not offering opinions in that other matter, to your knowledge, about what caused the opioid crisis. Is that correct?

A. That's correct.

Q. Doctor Gupta, I'm going to ask that Exhibit 58 be put up on the screen. I'm just going to give you a moment to take a look at it, please.

MS. MAINIGI: Exhibit 58 is Plaintiffs' Supplemental Federal Rule of Civil Procedure 26(a)(2)(C) Disclosure, for the record, and I believe it's Exhibit 1 to docket No. 1146 dated October 23rd, 2020.

MR. RUBY: And Teresa, this is marked

-- we'll get you -- this is a new exhibit that wasn't in the last depo, so we'll get you this and the other new ones after the depo today.

MS. MAINIGI: And for the record, I will just note that the only -- the only thing we've done with Exhibit 58 that makes it different than what the plaintiffs filed, is we've added some numbers at the beginning next to the bullet points just so it's easier, Doctor Gupta, for you and I to refer back to different ones of these.

That's all we've done, and they've been added, at least in the copy that I see, in red here.

GUPTA DEPOSITION EXHIBIT NO. 58

(Plaintiffs' Supplemental Federal Rule of Civil Procedure 26(a)(2)(C) Disclosure (marked with red numbers) was marked for identification purposes as Gupta Deposition Exhibit No. 58.)

BY MS. MAINIGI:

Q. Doctor Gupta, take a moment, if you need to. But do you recognize this document?

A. I'm looking at it now. I could read through it.

Q. Do you see, Doctor Gupta, that this document reflects that it is a summary of your opinions?

A. The page in front of me right now, yes.

Q. Okay. Have you seen this document - and I don't mean the version with numbers, but have you seen any version of this document - before today?

A. No.

Q. Did you sit down with your attorney or attorneys and prepare a document of this type, to your recollection? I don't need to know about the conversation; I'm just asking if you had a process of sitting down with your attorneys to prepare such a document.

A. No.

Q. Were you aware this document had been prepared on your behalf?

A. It may have been referred to, that there are some points, but I was not aware of specific. I'm seeing only Bullet Points 1 and 2.

Q. We can go ahead and scroll through the rest of the document so you can have a feel for it.

MR. RUBY: And Doctor, I can stop if you want to review particular points here. Tell me

what would be helpful to you.

THE DEPONENT: If you could just go back up a little bit, just slowly, from No. 3 on down.

MR. RUBY: Tell me when you're ready to move on down.

THE DEPONENT: Okay.

MR. COLANTONIO: I'm sorry, what was the question?

MS. MAINIGI: Well, if there's one pending - which I can't remember - I'll withdraw it and ask this question:

BY MS. MAINIGI:

Q. Doctor Gupta, now that you've had a moment to review this document, does it refresh your recollection that you participated at all in its preparation?

MS. KEARSE: I think he's still reviewing it.

THE DEPONENT: Yeah, just if we could move down to 9, please.

A. So my answer would be no.

Q. I'm sorry?

A. My answer would be no.

Q. Thank you. Just perusing these statements -- and I'm not asking you to review them chapter and verse. We will do that shortly. But do they generally look like some of the things you happen to have said at your last deposition?

A. I think they're fairly close to -- so my point of view.

Q. And your point of view, you -- I assume you'll agree with me that some of these statements are just pure facts that could be proven or disproven, correct?

A. I'm sorry, facts that can be disproven?

Q. Well, facts that can be empirically proven or disproven, correct?

A. I would say my statements stand for themselves as they are.

Q. Well, I guess let me ask it this way: Some of these statements are facts and some are opinions. Correct?

A. I'm happy to go through these and we can discuss. I can't give you an opinion one way or the other for all of the points.

Q. Fair enough. Fair enough. Before we start getting to some of these opinions, can we go to

Footnote 27, please?

A. I'm going to move the video box out here so I can read.

Q. Sure. Let me know when you're done reading Footnote 27.

A. So I'm done reading Footnote 27.

Q. Okay. Let me ask you about the first statement in Footnote 27. It says you are a "practicing internist with 25 years of clinical experience." Is that correct?

A. I'm going to calculate the years and get back to you. I began practice in 1993 originally, so that would be a little more than that, if we calculated from there.

So that's more like - 21 plus 7 - 28 years. If you look at post residency, that's 1999, that would be about 22. So yeah, 22 to 27 years, which makes 25 right in the middle.

Q. And that's 25 or 22 to 27 years as a practicing internist, correct?

A. Correct.

Q. The footnote also notes that you have authored more than 125 peer-reviewed scientific publications. Is that accurate?

A. That's correct.
Q. How many of them have to do with opioids?
A. I couldn't tell you right here.
Q. Would it be fair to say maybe one has to do with opioids?
A. I think it would be very difficult for me to venture that guess right now.
Q. Let's go to your CV. And let's go to page 27, Item No. 27. Can you describe Item No. 27 on page 27 of your CV, please, Doctor Gupta?
A. I can just read that out to you. "Gupta, R. Another ill of prescription opioids. Abstract and Commentary. Internal Medicine Alert. 2014; 36(9):68-69."
Q. Now, was this a peer-reviewed scientific publication?
A. This -- generally the Internal Medicine Alert publications are a peer review of a peer-reviewed publication.

So generally there will be reviews that will be published as peer reviews, and experts like myself would provide a review of the peer-reviewed material.
Q. So you're doing a review of the review; is

that right?

A. As an expert.

Q. Okay. And the Internal Medicine Alert, is that essentially an online newsletter for internists?

A. It may be online, but I have also seen paper versions of it. It has a distribution of about 200,000 primary care physicians and internists all over the country.

Q. The work for this, Another ill of Prescription Opioids piece, that wasn't research you did yourself, correct?

A. The abstract and commentary that I would have written would be the research I would have done myself.

Q. What research did you do for this commentary?

A. Ms. Mainigi, I sitting here, I could not tell you what research I did seven years ago for a random article that is in my list -- my CV at this point. I'd be happy to go back and look it up and get you the answers, but I just couldn't -- I'm sorry, I don't have that type of memory.

Q. And that's fine, Doctor Gupta. But just to

confirm, this -- this was one of those reviews of a review that you mentioned?

A. That's what I just stated.

Q. Okay. And so then the manner in which you did this is: There was a review that was done, and you reviewed that review, correct?

A. I will -- I'm happily able to restate this now for the record, which is: Generally what happens is that there are all kinds of publication, review articles, clinical trials and other peer-reviewed literature that is published in the field of medicine at large.

The -- the editor in chief of the magazine, of this particular journal, requests particular -- those of importance -- significant importance, articles that are out there, requests the editorial board to -- for those particular pieces, to review that, conduct research around that article, conduct parallel research of other articles, and then use their expertise and specialty and experience to put together an abstract and a commentary, which is then further reviewed by the editor in chief. So it is peer reviewed, and then it gets published into this

journal called Internal Medicine Alert.

That would be a very similar process for not just this, but other publications of similar nature on my resume as well.

Q. And so I think there is a number of items, of which this is one, on your resume that you describe as peer-reviewed publications. That's generally what you mean by that, what -- the definition you just gave, correct?

A. I just explained it.

Q. Going back to Footnote 27, please --

MR. RUBY: Coming.

Q. -- this footnote also notes, Doctor Gupta, that you are a "national and global leader in transforming public health practice to advance health equity and create healthier communities." Do you see that?

A. Yes.

Q. And do you agree with that statement?

A. Yes.

Q. The last sentence notes that you were named West Virginian of the year for your work toward battling the opioid epidemic by the Pulitzer prize-winning Charleston Gazette-Mail. Do you see that?

A. I see that.
Q. Is that accurate?
A. That's accurate.
Q. What was the work that caused you to be named West Virginian of the Year?
A. I'm happy to go into the details of the work. This was in -- something that was -- this happened in December, end of 2017. That would have been included with my work from 2015, '16 to '17. I'll start with the high points.
Q. Let me just interrupt you for one moment, Doctor Gupta, because I want to get into the details in a little bit.
MR. COLANTONIO: Do you want him to finish his answer, please?
MS. KEARSE: Yeah, Enu, can he complete his answer, please?
Q. Well, what I'll ask you, Doctor Gupta, is just give me the high level, and then we're going to come back in greater detail later.
MS. KEARSE: Well, Enu, you had a question pending and specifically asked him about this award, so I think he can answer as complete as he --

MS. MAINIGI: Okay, that's fine.

Q. Go ahead, Doctor Gupta.

A. So basically my work from 2015 and '16 and '17, it was the totality of the work that was recognized for this award. That really required a asserted effort from day one, so going back, very beginning, one of the first -- when I came into the office in January of 2015, it became my priority number one, priority number two and priority number three, to start addressing or help address the problem of the overdose deaths that we were facing, as well as the nonfatal overdoses and the carnage and the killing that was happening in West Virginia around the clock of people because of the opioid crisis.

So the first thing we did was: We created the first -- funded the first Harm Reduction Program by providing seed funding to Cabell-Huntington Health Department in Cabell County, so we initiated that program.

I helped not only fund, but helped begin that program with Doctor Kilkenny, as I mentioned, worked very closely with Doctor Kilkenny in Cabell-Huntington Health Department.

We then continued to utilize the model of Cabell-Huntington Health Department's Harm Reduction Program to expand to other areas of the state. In early 2017, I continued to see 15 to 20 percent rise in overdose deaths year after year after year, so along with working to write the 1115 Medicaid waiver, expand -- remove the barriers to treatment, work legislation, create the Office of Drug Control Policy at the State level --

One of the important things we did is: We conducted a social autopsy. The social autopsy that was conducted, we looked at all of the deaths from overdose that happened in 2016. We -- we did a CSI type of investigation to look at people's deaths in the year before their deaths.

We had very significant findings that included that 90 percent of decedents have an interaction with the -- you know, the PDMP or the prescription drug monitoring -- Controlled Substances Monitoring Program in West Virginia, as we call it, and we found that a significant percentage of women -- so half of the women that died had filled a prescription within 30 days of their death.

We also found that if people went to multiple pharmacies, that chances was as high as 70 percent of dying because of overdose. We -- so we had very significant findings like these, because of which then we -- I put together a team to create an opioid response plan of national and state experts, including John Hopkins University, Marshall University and West Virginia University.

They came out with a plan, 12-point plan. We -- I submitted that plan to the Governor. As a result of this, basically -- and I don't want to like take too much of this time. But what happened was: Before I came, the rate of prescription drugs and after I left, in the country, it was down by 30 percent; in West Virginia, because of these efforts, it was down by 53 percent.

In 2017 to 2018, because of the work of 2017, the paper was recognized nationally, the outcomes that would happen. That was the only year, from 2017 to 2018, that the nation had any drops in overdose deaths, and nationally, there was a drop of about 4 percent average. But in West Virginia, because of this work, we had 11 percent

drop, literally three times the drop we had of the national average.

And those are some of the reasons that -- the Gazette, Politico, PBS, a number of venues, publicly recognized the work and provided -- and as well as the Governing magazine and some others.

Q. So in your role as State Health Commissioner, you were able to have an impact on the opioid crisis. Fair?

A. I would say significant, yeah.

Q. Now, the West Virginian of the Year award in 2017, was that just you that won that award?

A. No, there were other colleagues as well. I don't remember exactly who the other colleagues were, but there were other colleagues. Some years, it's given to one person; other years, it's given to multiple people.

Q. So you weren't the sole West Virginian of the Year, right?

A. Right.

Q. Okay. Do you recall that in fact the 2017 West Virginian of the Year award was given to everyone who was working to combat the opioid

epidemic?

A. You know, of the 5,000 employees at DHHR, I do not recall that everybody was given that award.

Q. Okay.

MS. MAINIGI: Let's put up Exhibit 61, please.

Q. And Exhibit 61 is 12-31-17 Charleston Gazette-Mail written by Erik Eyre, "Men and women battling the opioid epidemic."

GUPTA DEPOSITION EXHIBIT NO. 61

(Charleston Gazette-Mail article dated 12-31-17 entitled "Men and women battling the opioid epidemic" was marked for identification purposes as Gupta Deposition Exhibit No. 61.)

Q. And do you see at the top there that there's a feature -- there's reference to Huntington Fire Chief Jan Rader?

A. Yes.

Q. Okay. And do you see where it says, "Rader is one of thousands of West Virginians staring down the opioid crisis?"

A. Yes. Could you --

THE DEPONENT: Can you just move the

slide up a little bit? Because it's covering up the top pieces of this manuscript. The top.

Q. Do you see where it says, "Rader is one of thousands of West Virginians staring down the opioid crisis," Doctor Gupta?

A. I do not, actually.

Q. Let's highlight it for you.

A. Yeah, I --

Q. You see it now?

A. Yeah. I would really request to see the entire document rather than reading one sentence.

Q. Well, do you see where we've highlighted, Doctor Gupta?

A. I can see the highlight.

Q. Okay. And what does the highlight --

MS. KEARSE: If Doctor Gupta wants to review the whole document, please allow him to review the document. And I'm sure he doesn't -- he'll answer your questions, but --

MS. MAINIGI: Well, he certainly can review the document in a moment, but I'm just asking if he -- if he sees where it says -- it's highlighted now.

MS. KEARSE: Enu, with all due

respect, I believe he should be able to look at the document before you answers a question about the document so he can put it in context.

MS. MAINIGI: Okay. But I'm just asking him, Anne, and I don't want to argue back and forth with you, because we're not supposed to do that.

BY MS. MAINIGI:

Q. Doctor Gupta, do you see where it says, "Rader is one of thousands of West Virginians staring down the opioid crisis." Do you see that?

A. Ms. Mainigi, you're not making me feel comfortable by not allowing me to be comfortable understanding the entire document.

Q. Do you see the highlighted paragraph, Doctor Gupta?

A. Ms. Mainigi, I do see the highlighted paragraph, but I am not comfortable the way I'm being treated right now.

Q. Okay. Let me read the highlighted paragraph to you, Doctor Gupta. It reads as follows: "Rader is one of thousands of West Virginians staring down the opioid crisis. They are firefighters, police officers, social workers,

paramedics, emergency medical technicians, nurses, doctors, pharmacists, counselors, emergency room workers, psychologists, detoxification center employees, public health officers, people in recovery, and families who've lost loved ones to addiction and now provide comfort and a helping hand to others. They're all working to combat the opioid epidemic.

And they are the Gazette-Mail's West Virginians of the Year for 2017."

Did I read that paragraph correctly, Doctor Gupta?

A. Abstract-wise, yes.

MS. MAINIGI: We can take that off the screen.

MS. KEARSE: No, no, Enu, you can't take it off the screen now. He just asked to review the document, so --

MS. MAINIGI: He can certainly review the document at the next break, Anne, if he would like. I'm moving on.

MS. KEARSE: Let's take a break --

THE DEPONENT: Then, Ms. Mainigi, I can't continue this dep --

MS. KEARSE: Let's take a break right now so he can review the document -- and Steve, if you sent -- I don't know if I got that -- I don't see that on my e-mail that you sent me that document anyway, but --

THE DEPONENT: I would like to take a break.

MS. MAINIGI: I don't have anything more. This is --

THE DEPONENT: I'm requesting a break.

MS. KEARSE: We're going to take a break right now, Enu. Can we take a break, please?

MS. MAINIGI: Okay. Hang on one second. Let me see where I am on my outline. Yes, we can take a ten-minute break. Is that okay?

THE DEPONENT: I want to take a fifteen minute break.

MS. KEARSE: Okay.

MS. MAINIGI: Well, I hope then Mr. Gupta can stay past 4:00 o'clock because we've got to keep the breaks tight since you gave us limited time.

MR. COLANTONIO: He'll agree to ten minutes past 4:00 o'clock if that's a problem,

since we're going to take fifteen minutes instead of five. How's that?

THE DEPONENT: Ten. Fifteen instead of ten.

MR. COLANTONIO: Yeah, five minutes, yeah.

MS. MAINIGI: Okay, it's 12:54. And we'll be back in fifteen minutes then. How about by 1:10, we're back. Is that all right?

MS. KEARSE: Yeah, we can go off the record. Enu --

VIDEO OPERATOR: Going off the record. The time is 12:54 p.m.

(A recess was taken after which the proceedings continued as follows:)

VIDEO OPERATOR: We're going back on the record. The time is 1:10 p.m.

MR. COLANTONIO: Yeah, so just before we start, I'd like to --

MS. KEARSE: Enu, I want to raise one issue before we go back on the record, and we've been doing depositions now for a long time, and I know you're well aware of the deposition protocol, that we're all doing every accommodation we can

have for you to provide Doctor Gupta and to get the exhibits there. There are provisions that he should have a hard copy document in addition to be able to read the document beforehand, so I ask you to please at least --

You know, since we did not get these exhibits, some of these exhibits, in advance, nor even get notice of this exhibit, please, with, I guess, just a common courtesy, to let the doctor review the exhibit in totality before you ask questions there, and also it's part of the protocol. It's common in professional courtesy as well.

MS. MAINIGI: And Anne, certainly, for the record, I think most exhibits were e-mailed to you all, and it was understood by us that you would be printing them out for Doctor Gupta's use. We found out at the beginning of the deposition that was not going to be the case, but --

MS. KEARSE: Well, we didn't get -- we did not get Exhibit 61, for the record, so -- but go ahead.

MR. COLANTONIO: And let me also just say that during the break, Doctor Gupta's had now a

chance to review the full document, and so he'd like to finish his answer regarding that particular document.

MS. MAINIGI: I will certainly -- after 4:00 o'clock, if you want to ask him about --

MR. COLANTONIO: Go ahead, Doctor, just put your statement on the --

MS. MAINIGI: No, no, no, no.

THE DEPONENT: I just wanted to say that I did have a chance to --

MS. MAINIGI: Doctor -- Doctor Gupta, stop talking.

(Overtalk)

THE DEPONENT: I want to --

MS. MAINIGI: Doctor Gupta, please stop talking. There is no question pending right now, and after having rehearsed an answer with your attorneys, I do not need you - with all due respect, sir - to come in and give me your rehearsed answer.

MR. KEARSE: Enu, for the record, this is Anne defending this deposition. You actually stated that he could review the document on the break. He reviewed the document on break and now

he's able to finish his questioning regarding your questions about this document.

So I think it's quite appropriate now that he's reviewed it. You didn't let him review it while he was on the record, so he's now reviewed it, so if he just --

MR. COLANTONIO: I just want to place on --

MS. MAINIGI: Okay, Doctor --

MR. COLANTONIO: Hold on a second. I want to place on the record that I object to your statement that somehow there's a rehearsed answer, and I take umbrage to that, and just for the record, I want to put that on the record.

MS. MAINIGI: Okay, understood.

BY MS. MAINIGI:

Q. Doctor Gupta, could you please pull out Exhibit 58 again? I don't know if your counsel has printed it out for you now, but it is -- it is the statement that they filed with the Court with all of your opinions that has led to this deposition.

Let me know if you just want it on the screen, and we are happy to leave it on the screen.

A. It's already on the screen.

Q. Okay, terrific. I'm going to ask you about the first bullet, and that first bullet reads as follows: "Opiate prescription drugs, their volume, and the consequential addiction and other diseases associated with OUD rose by thousands of percent over a decade."

Did I read that correctly?

A. That's what it says.

Q. Do you agree with this statement?

A. I'm not sure if I agree with the entirety of the statement.

Q. Okay. What part of the statement -- and I don't need the reasons yet, we can break that down, but what part of the statement do you agree with or disagree with?

A. I don't agree with the statement, period.

Q. Okay. So let me just ask you one follow-up question on that and then we can move on to another opinion of yours. Where it says "thousands of percent over a decade," do you have any idea what decade is referenced there?

A. Ms. Mainigi, you're providing me this document. I don't have -- you know, I'm -- you're asking me a question if I agree to the statement.

I said I don't agree with the statement. So you're welcome to ask me questions, but I can't guess what you're thinking.

Q. Okay. Do you recall making this statement at your last deposition?

A. I do not.

Q. Okay. So you don't know what -- just for the record, the word "decade" in that statement, the first bullet, you don't know what decade is being referred to there.

A. I would request to you once again, after the break now, that if you intend to show me a statement, please provide me the context, because it's really unfair and misleading for me to be able to react to a statement without having any context, and you're doing it again.

Q. Okay.

MS. KEARSE: Enu, if you want to show him the page numbers on the deposition --

MS. MAINIGI: I don't. I'm just going to go off of this document that you all filed on his behalf, Anne.

Q. Okay. So let's move on to --

MS. KEARSE: You referred to his

testimony, so -- in his deposition, so --

MS. MAINIGI: Please, Anne, I'd appreciate it if you'd not have a speaking objection.

MR. FARRELL: Hold on, hold on. Enu, this is Paul Farrell. This isn't a speaking objection. What I'm saying is that the back and forth, we are both having objections to.

We did not file this document on his behalf. This is a document that we filed to give disclosure to the Court about the opinions that he offered during his deposition that we anticipated he would say at trial.

So I think that everybody is getting a little loose with their words and accusations, and so we will respect you and your questions, and I ask that you do the same, and so representing this document to be something that it's not, I object to.

MS. MAINIGI: Okay. Thank you, Paul.

BY MS. MAINIGI:

Q. Doctor Gupta, if you could take a look at the sixth bullet which is labeled by us 6, and just take a moment and read that, please, sir.

A. Okay.

Q. The sixth bullet reads as follows: "The HIV outbreak in Cabell County, as a result of IV drug use, is the second largest in the nation's history." Do you agree with that statement?

A. I'd have to know more about what you're talking about.

Q. Do you recall making a statement of this type at your last deposition, Doctor Gupta?

A. Once again, Ms. Mainigi, if you have my deposition, please be transparent and show it to me. I can't recall every word of my deposition.

Q. I'm sure you can't. Doctor Gupta, let me just represent to you that the plaintiffs in this matter filed -- filed a document which is the document in front of you, and represented that these were opinions and factual statements of yours that they derived from your prior deposition.

A. You have me right here. You can ask me directly.

Q. Okay.

A. You don't have to --

Q. I'm going to keep doing that, Doctor Gupta. Thank you.

Okay. Are you aware of an HIV outbreak in Cabell County that was the second largest in the nation's history?

A. Please be more specific.

Q. I cannot be. If you're not able to answer that question, that's fine, Doctor Gupta. I'll move on.

A. I'll be happy to answer if you provide me the context and the specifics.

Q. Are you aware of any HIV outbreak in Cabell County that was a result of IV drug use?

A. Yes.

Q. And what can you tell me about that?

A. I would have to recollect by memory, and I do not have a very good recollection to provide you any meaningful information other than there was an HIV outbreak related to IV drug use in Cabell County.

Q. And do you -- can you give me an approximate year?

A. It may have been in 2018 or '19. I do not recollect at this point.

Q. And do you believe that outbreak was the result of IV drug use?

A. That's my recollection.
Q. And what do you base that understanding on, that that HIV outbreak was the result of IV drug use?
A. On my memory.
Q. Did you compile any underlying information related to the HIV usage and the IV drug use and the correlation between those two?
A. Are you speaking specific to the outbreak, or overall my responsibilities as the State Health Commissioner or my responsibility as the County Health Officer?
Q. Specific to the outbreak.
A. As I said before, I do not have a really good recollection to a point I can provide you informed information at this point. If you'd give me the documents, I'm happy to share with you my opinion.
Q. What documents would you need?
A. Whatever you're alleging. Whatever you just stated, the compilation of reports, investigations. I'm happy to look at those.
Q. Unfortunately, I don't have anything besides this, Doctor Gupta. But let's move on.

Let's go to the bullet that has a 10 in front of it. Take a moment, please, and read that bullet. Let me know when you're ready for me to ask you questions.

A. One second.

Q. Sure.

A. Okay, I've read that.

Q. Let me just read it out loud -- excuse me. -- out loud for the record. Excuse me. "Because of the overwhelming number of overdose deaths in 2015, there was a need in West Virginia for air-conditioned trailers to house the bodies of those who had overdosed."

Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. Yes.

Q. And that is a statement of fact, correct?

A. Correct.

Q. What is your source of information for that statement of fact?

A. So I was also overseeing the chief medical office of -- the Office of the Chief Medical Examiner and one of the things we had to do was

purchase trailers - now, I could not tell you if they were air conditioned or had fans or what in them - but we had to purchase trailers to be able to house the dead bodies that were coming one every 8 hours to 12 hours because of the overdose deaths resulting from -- you know, obviously from drug overdose.

So we had to do that in the years during my tenure.

Q. And do you specifically remember doing that in 2015?

A. I specifically don't remember at this time, but I do clearly remember doing it.

Q. Okay. And in 2015, the drug overdose deaths were from what drugs mainly?

A. I couldn't tell you right now. I mean, I'd be happy to look at the charts that we produced, the report I looked at from 2000-2015. I mean -- but broadly without reviewing the data right now, I could tell you they were generally a combination of opioid prescriptions, heroin and fentanyl as well as other polysubstance use.

Q. Do you remember being deposed in 2016?

A. I don't remember the exact deposition.

Q. Okay. And I'm sorry, let me -- let me give you a little bit more than that. Do you recall that you were deposed in 2016 in an opioid case?

A. Yes.

Q. Now, I will represent to you that your deposition in 2016 did not mention that the Office of Medical Examiner had needed air-conditioned trailers in 2015. Is there a reason you omitted that fact from your 2016 deposition?

MS. KEARSE: Objection.

A. I don't recall if the defendants asked me that question specifically.

Q. Let's move on -- I'm just jumping around a bit. But we'll cover all of these, Doctor Gupta. Let's move on to Statement No. 13, if you would, please, sir. And if you'd take a moment and just read that.

A. I've read it.

Q. Let me read that out loud for the record. "In 2016, a significant amount of the people who died from an overdose had filled a prescription within 30 days prior to their death." Do you agree with that statement, Doctor Gupta?

A. Those are findings of the facts.

Q. And they are findings of fact from where or what?

A. From the social autopsy report we published which is available for you to review.

Q. Okay. I believe that was one of the exhibits that was e-mailed to your attorneys last night.

MS. MAINIGI: I'm assuming you all still have not printed out any of those documents, so we can put that up on the screen for you.

What exhibit number should we use for that? 62?

MR. RUBY: This was already marked as Plaintiff's 2 from the September deposition.

MS. MAINIGI: Oh, terrific. Okay, so we will leave it as Plaintiff's 2. It's a plaintiff's document.

BY MS. MAINIGI:

Q. Was that fact, Doctor Gupta, from this report, the 2016 West Virginia Overdose Fatality Analysis?

A. Yes.

Q. And several of the facts in this document that we've been reviewing are from this report.

Does that sound right to you?

A. I'd have to go back and check each one.

Q. Okay. Now, you ordered this report while you were commissioner and State Health Officer; is that correct?

A. So one of the -- one of the roles that we omitted today talking about the role of the Commissioner/State Health Officer is actually the obvious, which is to commission reports. And this was certainly one of the several reports I had commissioned to be conducted because I was so terrified of the deaths that were happening because of overdoses around the clock in the state of West Virginia when I assumed office.

Q. Okay. Let's turn to the third page of the report. This is the third page of the report, Doctor Gupta, and the third page lists the people who prepared the report, correct?

A. Will you allow me to review the whole page, please?

Q. Sure. Go ahead.

A. Thank you. I just want to see the corners of the page, make sure -- the bottom corner, those are all the people.

Yes, it does.

Q. Okay. And is it fair to say the lead authors of this report were Sarah Sanders, from the Violence and Injury Prevention Program and Christina Mullins from the Office of Maternal, Child and Family Health. Is that correct?

A. If you would move to the first page, it also has a couple of names on there. I just want to make sure there's no conflict there. The page before this. Sorry.

Yeah. So yeah, at the bottom of this first page, you have two names. Those are the same as the ones you mentioned, so the answer is yes.

Q. Those are -- those two individuals are the primary authors of the report. Correct?

A. We -- yes, we generally list the primary authors on the first page.

Q. And then the third page also lists perhaps 16 or so people who supported the report in some fashion. Correct?

A. This was a multi-disciplinary, multi-faceted report, and so all of these individuals played a critical role in the publishing of this report.

Q. And your name is not listed among these individuals, correct, Doctor Gupta?

A. As the Commissioner who commissions the very execution of the report, it would -- I would not be listed as also the preparer, writer or investigator of the same report.

Q. And you didn't -- as the commissioner of the report, you didn't perform any of the analyses in the report then, correct?

A. I provided the guidance.

Q. And what was the guidance you provided for this report?

A. I provided the guidance of the year of the report, the weight of the report, meaning the epidemiological guidance that was acquired in order for this to be conducted.

I provided the ability for us to have direction and facilitate the work of this report, basically, and clearly this was a report that was interagency report, so I was -- I had -- when we talked about this report, this was not just a -- data that came from the Bureau of Public Health.

It involved work and data from the State Medicaid agency, EMS agency, Medical

Examiner's Office, Department of Military Affairs and Public Safety. And a number of others. So it was very critical to have the highest level of direction and relationships.

So I was responsible for overseeing every and all aspects of this report, including engaging the Centers for Disease Control and Prevention.

Q. Does it say somewhere in here what you just said, that you were responsible for engaging on every part of this report?

A. Ms. Mainigi, that's what state health commissioners do across this nation.

Q. Let's go to the prior page where your name is. And this page lists also Jim Justice, The Governor; Bill Crouch, Cabinet Secretary for the Department of Health and Human Resources; obviously you; and then Jim Johnson, Director of the Office of Drug Control Policy; Anne Williams, Deputy Commissioner, Health Improvement Bureau for Public Health; Christina Mullins, Director for the Office of Maternal, Child and Family Health.

Do you see that?

A. Yes.

Q. Did all of these individuals also engage in the way that you described your engagement?

A. My engagement was fulfilling the role of the Commissioner. Other individuals did not have that responsibility. They had very important roles to play, but not one of the Commissioner and State Health Officer for the State of West Virginia.

Q. Coming back to the statement that is numbered 13 on Exhibit 58, please, can you tell me what the phrase "a significant amount" refers to?

A. Certainly. Let's go back to that report.

Q. Well, I'm just asking if you know sitting here, Doctor Gupta, what "a significant amount" refers to.

A. I'm asking you, sitting here, please, let's go back to that report, because that's where the answers are.

Q. Okay. The answers are in the report?

A. Of course. You just mentioned that a lot of these bullets came from that report, so I'm reading out of your statement back to you, and that's a -- that's true.

Q. Okay. And is it fair to say that you wouldn't be able to tell me what "a significant

amount" refers to without aid of that report then?

MS. KEARSE: Objection.

A. I think it's fair to say that I would like to make sure I have access to the report. Let's go back to the facts and look at it rather than to -- to err on the side of facts, being able to look at the report.

Q. Okay. So Doctor Gupta, let me ask my question again. Is it fair to say that without the aid of the report, you're not able to tell me what the phrase "a significant amount" in this bullet means?

MS. KEARSE: Objection.

A. I can tell you, but I would like to be certain. And I -- I mean, look, I can tell you. What that means is: For women, about 49 percent of women have died within 30 days of filling a prescription; for men, it was, I believe, around 36 percent that died within 30 days of filling a prescription.

But I really hope you stick to the facts of the report and not my memory from several years ago. But it's up to you.

Q. Okay, understood. And assuming that those

numbers are correct, your 49 percent and your 36 percent, those are statements of fact, not opinion, correct?

A. That's correct.

Q. And the data that went into compiling those numbers, that was data that was compiled presumably by the authors of the report?

A. Correct.

Q. And the statement related to the significant amount, or the 49 percent or the 36 percent, was that a number state-wide?

A. Yes.

Q. And you don't know whether that number was specifically true for Cabell or Huntington, correct?

MR. COLANTONIO: Objection.

A. Sitting here, I do not have that recollection.

Q. Okay. And let me --

Someone objected to the form of my question, so let me ask it separately. You don't know if the numbers in that report, the 2016 West Virginia Overdose Fatality Analysis applied specifically to Cabell County, correct?

A. I could not tell you my recollection of which percentage of those or what percentage applied to Cabell County and City of Huntington at this time.

Q. And do you know whether the statement about overdose deaths caused by opioid -- is the statement related to overdose deaths caused by opioids or by all substances?

A. The controlled substances. The -- what we did was: We saw the interaction with the Controlled Substance Monitoring Program, which is the West Virginia's version of prescription drug monitoring program, and as we interrogated the CSMP, as we call it, against the deaths, those were the numbers that came about.

And generally when we speak about controlled substances in West Virginia, that, once again, generally refers to opioids because of the significant volume of opioids both in prescribing as well as in diversion that existed at the time.

Q. Can you define "diversion" for me just so we have it for the record, Doctor Gupta?

A. Sure. Diversion of any substance or any medication is the use of that for purposes any

other for -- any other than for prescribed use, legitimate prescribed use.

Q. And is diversion usually illegal?

A. Yes.

Q. And is an example of diversion, someone gets a prescription for 30 days, only uses three pills, leaves the bottle in their cabinet and someone who's the not the person for whom the pills were prescribed takes those pills for themselves and utilizes them? Is that an example of diversion?

A. That's not the only example, but that could be one example. But the writing of prescriptions that may not be legitimate for someone may also be diversion.

Q. What are other examples of diversion that occur to you?

A. Borrowing from friends or family. Children getting into the closets -- the drug closets and taking it from their parents is another example. Stealing from each other or from friends or from family is another example.

Sometimes when you prescribe 30 days of opioids, you know, Lortab for a tooth pulled and

then you leave it in the cabinet after two doses and next month you get a leg sprain and you start to use it again, that's also diversion sometimes of the same person, because that was not the intended use.

So there's multiple -- you know, of course, everything from misuse, ill use, illegitimate use, borrowing, to all the way to selling on the street.

Q. So diversion generally occurs after the prescription has left the pharmacy; is that correct?

A. Not necessarily. If they're being written for a purpose that is less than legitimate, as we have also seen lots of bad doctors writing prescriptions, running pill mills, that's also diversion that happens reportedly when it gets to the pharmacy.

Q. The other examples you gave me just in your prior answer, those are examples -- besides this one, those are examples of diversion that occur after the prescription leaves the pharmacy?

A. Correct.

Q. So the 49 percent and the 36 percent that

you mentioned that you recall, I just want to ask you: Is that -- would those numbers, in your mind, be different for overdose deaths caused by opioids versus other substances?

A. Not necessarily.

Q. Are there different numbers that existed for opioids versus other substances?

A. No. We would use synonymously for most purposes controlled substances utilization in CSMP with opioid prescribing for the purposes of this report.

Q. Okay. So for the purposes of this report, you didn't necessarily break down into prescription opioids, heroin, fentanyl and so forth.

A. No, no, no, that's not what I'm saying. What I'm saying is: When 49 percent of the female decedents -- we found -- so in all the female decedents in the year of 2016 that died from a drug overdose, we found that 49 percent of them had filled a prescription that wasn't a heroin prescription, that was not a meth prescription, that was actually a controlled substances prescription, that's what we found from interrogating the Controlled Substances Monitoring

Program.

And because of the large -- super large volumes of opioids being flooded into communities through prescriptions, I think it's fair to assume that 49 percent had a very, very high proportion of opioids, if not all.

Q. So the report did not determine -- of the 49 percent that you reference, the report did not determine who actually died from a prescription opioid abuse versus someone who may have died from a heroin abuse. Correct?

A. So we're talking about two different things. All of these people died - they're dead - now we're going back and studying what was the characteristics of that. So if you look back at the report, at the top, it says, you know, we're looking at the medical system, utilization, characteristics of people and all of that. So this is a study that's intended -- the medical examiners already have demonstrated what they died of.

Now we're going back and looking at: What were the characteristics of these individuals that died? And we're talking about -- when we talk about 49 percent of women that died had filled a

prescription within 30 days of their death, explains that there were still a lot of prescriptions that were being dispensed that were the cause and contributions of death in those individuals.

Q. You cannot say - or the report cannot say, as I understand it - that 49 percent of the deaths in those cases were caused by the prescription that was filled within the last 30 days, correct?

A. What we can say is: Of the people that died from drug overdose, in those, 90 percent - that means nine out of ten people - had interacted with the Controlled Substances Monitoring Program. And from looking -- within the past year.

So nine out of ten people that died had some relationship/interactions with the State's CSMP. Now, when we hone that back to -- from one year to 30 days, we find that almost half of the women that died because of overdose had filled a prescription.

Q. But you don't know whether the 49 percent died because of the prescription that they filled, correct?

A. This study was not meant to be a direct

correlation/causation study, right? So this is not a causation study. So if you're asking me, was there a cause and effect, I would say that was not the purpose of our -- purpose of our work, basically.

But from an epidemiological standpoint, our assertions were that there's a reasonable degree of certainty that the continued interaction with Controlled Substances Monitoring Program had high likelihood played a role in the death of these individuals.

Q. Let's move on to the next statement, which is Statement 14. If you could take a moment and read that, please, sir.

A. I see it. I've got it.

Q. Okay. And let me read that statement out loud for the record. "Of the people who were incarcerated, released and subsequently died, the majority died of an overdose." Is that a statement you agree with, sir?

A. Yes.

Q. What is the genesis of this statement or the source of this statement?

A. The same report.

Q. Is it the 2016 West Virginia Overdose Fatality Analysis?

A. Correct.

MS. MAINIGI: If we could put that exhibit back up, please, the 2016 West Virginia Overdose Fatality Analysis. And let's go to the Table of Contents.

Q. And while we're doing that, Doctor Gupta, I just want to confirm that you didn't do any independent research on your own to come to this conclusion that is No. 14. You derived the conclusion from the report, the 2016 West Virginia Overdose Fatality Analysis, correct?

A. Correct.

Q. Okay. Where do you think we could find that statement?

A. You could actually do Ctrl-F and find it.

Q. What would you like to do Ctrl-F on?

A. Incarceration.

Q. Do you see any particular section of this report that it would perhaps be included in? We'll see if Ctrl-F works. I don't know if it will.

A. Ms. Mainigi, would you like me to pull up this report myself on my computer? Because I would

like to really have a fair -- you know, a way where I could see the same thing you guys are seeing, because I feel like I'm being handicapped here.

Q. No, and I apologize for that.

A. Right there at the bottom. Right there -- page -- please go up. Go up, please.

MR. COLANTONIO: Back a page. Do you see that?

Q. Back a page, okay.

A. 18 -- yeah, go up. Move down, I'm sorry.

Q. Sorry.

A. There is Corrections, right here, 4.4.4, I think. That actually will not be. So I -- maybe 3.6. 3.6, page 18 perhaps.

Q. Okay. Let's take a quick look, and otherwise we can keep going for now.

MR. COLANTONIO: You want --

THE DEPONENT: Mine is here.

MR. COLANTONIO: I'll get it.

THE DEPONENT: Yeah, I can speed this up a little bit.

Q. Actually, Doctor Gupta, I ask that you not pull out a computer in the middle of your deposition. I'm asking you to not do that, please,

sir.

A. Then please provide me that report.

Q. Okay, it was provided -- the report was provided to your counsel last night. But I'm just -- right now, let's see what we can do with what we have on the screen. Do you see that fact on page 18?

A. I don't see that. And please pull that fact up for me. If you have the wheel here, please pull that up and I'm happy to comment on it.

Q. Okay. While we --

MR. RUBY: This is -- this is Page 18. This is the --

MS. MAINIGI: I'm sorry.

MR. RUBY: this is page 18. This is what the doctor referred to.

MS. MAINIGI: Yeah. I don't see it. Let's go to page 19. Okay, I guess it moves on to something else.

Q. Well, it does not appear -- let's -- we'll, on a break, see if we can find it in this report, Doctor Gupta, but let me ask you some information about this statement. Is this statement that you made at your deposition, "Of the people who were

incarcerated, released and subsequently died, the majority died of an overdose," is that limited to some scope of time, some period of time?

A. So we did the report looking one year before, people died, so one year prior to their death. So I believe to the best of my recollection, that the majority would have been -- around 56 percent of those died within a year of their release because of overdose, but I believe about 27 percent actually died within a month of release because of an overdose.

But that's my best recollection at the time.

Q. And does -- in terms of years that this covers, do you have any sense of whether this applies just to 2015 or some other time period?

A. So the report covered all the deaths in 2016, and we would look at their life one year - that's 12 months - prior to their death. So if someone died on March 31st of 2016, we would have gone back till March 31st of 2015. If someone died on November 11th of 2016, we would have gone back to November 11th of 2015.

So for every individual as I mentioned

before, it was a CSI type of examination, very labor-intensive, to look at their life, their interactions in the 12 months prior to their death, and that's the way I would explain it.

Q. So just to be clear, does it refer to people who were both released and died in that time period?

A. Yes.

Q. So of all the people who were released during the time period, what percentage also died in the time period?

A. So once again, my recollection is that people who are released within 12 months, 56 percent of those people who died within 12 months of their release died because of an overdose.

I would really want to look at the report to make sure what I'm stating is factual, but that's the best of my recollection four years after the release of the report.

Q. And again, this is a statement of fact, correct? This is either something that -- this is something that was derived from existing factual information that was kept.

A. The statement that I make today sitting

here is to the best of my ability to recollect the facts that happened four years ago in the report.

Q. Do you know who compiled the information that went into this fact?

A. So as I mentioned before, there were multiple partners and agencies across the country that included within West Virginia, Department of Military Affairs and Public Safety, Department of Medicaid, Emergency Medical Services, behavioral health systems and behavioral treatment programs, Medical Examiner's Office, the Centers for Disease Control and Prevention, to provide the technical expertise. And there may be some others.

But all of that you can find in the report itself.

Q. So your information -- what you are relating to me is essentially secondhand information. Correct, Doctor Gupta?

MS. KEARSE: Objection.

A. I'm not sure what you mean by that.

Q. Well, you didn't compile this information. We agreed on that earlier, right?

A. I was the Commissioner who commissioned the report and oversaw every aspect of this report as

the supervisor for this report.

Q. Okay. Did you personally compile the information that went into this particular fact, Fact 14 that we've been focused on?

A. This report was conducted under my direction.

Q. Okay. That wasn't my question. Did you personally compile and review the information that went into Fact 14?

A. I was not one of the people that personally was compiling, because that's not the role of the Commissioner.

Q. Do you recall, sitting here today, who that person or persons would have been who compiled the information?

A. I think it was page 3 we just went over. So you may want to pull that back up.

Q. Would it have been somebody on that page, do you think? If we showed you that page --

A. Yes.

Q. -- would you remember who it was?

A. Which report are you talking about compiling?

Q. Well, I'm talking about compiling Fact 14.

You told me it was from the 2016 West Virginia --

A. Yes.

Q. -- Overdose Fatality Analysis.

A. Yes, Ms. Mainigi, I just want to make sure you understand this real well, because I'm seeing some signs you're not getting this part, so I apologize for that, because it must be me.

This report was a comprehensive analysis of a state-wide effort including multiple agencies in a multi-disciplinary way, so it's not a clerk sitting somewhere in an office with a laptop compiling.

It's a team of experts as you see on television that are constantly working together, understanding, analyzing, interpreting data and then putting a report together.

So it's a very dynamic work that took several months to put together so this is not -- you don't put a finger on somebody and say, "Ah-ha, that's the person." It's a -- it's a -- it was such a unique report that several states and jurisdictions since have replicated this work.

Q. So I take your answer to mean that it would not necessarily be possible sitting here today to

identify the particular person or persons who compiled particularly Fact 14.

A. And I am responding to you by saying, "Please look at page 3" and all those individuals have been an integral part of compiling the report that's bulleted on No. 14.

Q. Now, this Fact 14, that's not a statement that's specific to Cabell County, correct?

A. That statement includes Cabell County.

Q. It's a state-wide number, correct?

A. And Cabell County is part of state of West Virginia.

Q. Okay. And you didn't break out this number by state or city, correct?

A. We did have it by state. It was the state of West Virginia.

Q. I'm sorry. I may have misspoken. You didn't break out this number by county or city, did you?

A. We did not -- you're -- this report was not meant to be a county-by-county-by-county or city-by-city report. We do have other reports. If you'd like to see, we're happy to share with you. But that was not the purpose of this particular

report.

Q. Did you do -- do you recall a report off the top of your head, Doctor Gupta, that was specific to either Cabell County or Huntington city?

A. Yes.

Q. What was the report?

A. There was historical overview of overdoses from 2000 to 2015. It might have been 2001 to 2015. I'm sure you'll question that. So there -- when I came in, one of the first things I did was order that report.

Again, I commissioned it, a report, supervisors directed it, and it ended up being a historical first-time overview of the deaths that were determined and distinguished by gender, by county and all other factors.

I also did a very similar report, ordered/commissioned a report on HIV profiles across the state by county.

I also commissioned a report on Hepatitis for the last several years across the state.

I also did a report or commissioned a

report on neonatal abstinence syndrome across the prevalence of which -- across the state, that included Cabell County.

I did a specific report on the overdoses that happened where in five hours, we had over 28 people be overdosed, which became nationally known in Cabell County. We conducted a report with CDC and with Bureau of Public Health, with Cabell-Huntington Health Department, to conduct that as well.

As well as the HIV report we've already discussed.

Q. With respect to the 2000 to 2015 report, are you telling me that the information in that report is broken down either by county or city?

A. Yes.

Q. Thank you. Coming back to this statement, this Fact 14, with respect to the overdose, do you know whether the overdose death was caused by opioids, prescription opioids, or some other drug?

A. Which -- which -- the totality of deaths?

Q. Well, I'm just looking at the Statement 14 where it says, "the majority died of an overdose." Do you see the word "overdose"?

A. Yes.

Q. Okay. So with respect to that word "overdose," was the overdose caused -- the overdose which led to the death, was that caused by prescription opioids or a combination perhaps of prescription opioids -- some died of prescription opioids, some died of heroin, some died of fentanyl, some died of something else altogether?

A. To the best of my recollection, in this report, the overwhelming over -- drug overdose deaths were -- involved opioids. They could involve other substances too, but they overwhelmingly involved opioids.

Q. What about prescription opioids?

A. That's included, as you stated, in the overall category of opioids.

Q. Okay. And did you break that down? Did you -- as part of your autopsy, did you figure out the specific cause of death?

A. So Ms. Mainigi, when someone dies and you have to conduct an autopsy and you look at the substances in their body, the breakdown product of an opioid - whether it's from heroin or from Lortab or Vicodin - is no different. So you literally

cannot break down from the product, because they are all opioids.

Q. I'm going to go to your Statement No. 15, Doctor Gupta, next. Why don't you take a moment and read it.

A. Sure.

MR. COLANTONIO: Just to be clear, these aren't his statements. This is -- these are something written by somebody else.

MS. MAINIGI: I believe they're citing his deposition from last time. But thank you for that. Thank you for that speaking clarification.

Q. Let me know when you're done with it --

A. I'm done.

Q. -- Doctor Gupta. Okay. 15, for the record, says, "In 2016, it was found that those overdose decedents who went to three or more pharmacies to fill prescriptions were 70 times more likely to have died."

Do you agree with this statement?

A. I would love to see the report and the facts for themselves. But to the best of my recollection, it seems accurate.

Q. And so by your statement, I take it you

believe that this is another one of the facts derived from one of the reports you commissioned? Is that fair?

A. This was also the social autopsy, same report that we've been discussing.

Q. The 2016 report, Doctor Gupta?

A. Correct.

Q. Does this refer to people who went to three or more pharmacies to fill opioid prescriptions or any kind of prescription?

A. This goes back to, again, we interrogated the Controlled Substances Monitoring Program, which is the prescription drug monitoring program for the State of West Virginia. That means these controlled substances generally for category -- scheduled substances for Category II through IV, and this inclusion would mean filling of prescriptions from Schedule II to Schedule IV.

Q. Schedule II, Schedule III and Schedule IV, correct?

A. Yes.

Q. Okay. Oxy and hydro, what schedule are those?

A. They would -- well, it depends. What year

are you talking about for hydrocodone?

Q. The year the report was -- I'm sorry, I'm asking about the year the report covered.

A. OxyContin -- oxy of any type would be Schedule II, and you know, it depends on the hydrocodone product. Some were Schedule III and some were Schedule II at that time.

Q. And this report counted Schedule II, Schedule III and what was contained in the Schedule IV category, correct?

A. Correct.

Q. Now, this statement doesn't indicate that the prescription itself that they filled caused the death. Right?

A. It does not.

Q. And this statement doesn't refer specifically to Cabell, correct?

A. Cabell's prescriptions and pharmacies would be -- and people that live in Cabell, were included in the analysis of this report.

Q. You can't break out the numbers for Cabell, can you?

A. You can. We just didn't do it. But you can.

Q. And how about for Huntington? Did you break out the numbers for Huntington?

A. We did not. But you can.

Q. And this refers to people who went to three or more pharmacies in 2016 or 2015?

A. This would be, once again, 12 months prior to their time of death in 2016.

Q. Okay. Now, this statement is also a fact, correct?

A. Once again, to the best of my recollection - without having the report in front of me - from four years ago, I believe that is -- this seems accurate, but I cannot attest to it at this time.

Q. Okay. And in terms of how this information was compiled, the information was compiled and put together by presumably the same set of individuals that were on page 3, correct, of the report?

A. Right.

Q. Okay. I'm going to move on to Statement 16, Doctor Gupta, if you could take a moment and read that.

A. I'm done.

Q. The statement says, "Three out of the four people that died of an overdose in 2016 tried to

seek help within the year before their time of death." Is that a statement you agree with?

A. To the best of my recollection. I thought it was more like 80 percent, four out of five, but it could be either three out of four or four out of five. But a high number of people had come in the system, interacted with the health care system, in the 12 months prior to their death.

Q. And this, you would agree, is a statement of fact.

A. I would say that -- to my response in the previous question, that -- the response would be similar to that.

Q. Okay. And I'm sorry, Doctor Gupta, but I -- let me state that so that your answer is not unclear. By that, you mean it -- this fact, that is No. 16, is derived from one of the two reports that we've been discussing? Is that fair?

A. I cannot be certain of that.

Q. Do you know what the derivation is of this fact?

A. I'm sorry? Can you repeat?

Q. Do you know what the derivation is of this fact? Where did this fact come from?

A. As I stated previously, in the social autopsy report, to the best of my recollection, we saw close to 80 percent of the people that had died of an overdose in 2016 had tried to seek help from the health care system within the 12 months prior to their time of death.

And so while my recollection doesn't align with this statement exactly, that may be the source of the statement.

Q. Do you remember whether before you gave your deposition in September, did you read the autopsy report before you went in to your deposition?

A. I don't remember.

Q. Okay. In terms of who would have -- if in fact this is a statement from one of the two reports, the 2016 report or the '01 to '15 report, the information would have been compiled by the group of people that are on page 3? Is that fair?

A. That would be accurate.

Q. You didn't compile this information yourself, correct?

A. I oversaw, directed and commissioned the report as the Commissioner of Health of the State

of West Virginia, and obviously I approved the report to be published.

Q. The phrase "tried to seek help," what does that mean to you?

A. What that means is, from the report, what we found was that these individuals in the 12 months prior to their death from drug overdose had either visited an emergency room or had called an EMS or had seen somebody at behavioral health, but there were some interaction of them with the health care system.

Q. Do you have an impression or understanding of where the information came from for this fact?

A. As I stated prior, that the multi-agency, multi-disciplinary work that it took to put the social autopsy 2016 report together that I commissioned, oversaw, directed and managed and approved allowed various agencies across the State to work together to create this.

So information like this or similar to this in some form or shape would have come out from the work of the multi-agency within the State of West Virginia.

Q. But specifically, you don't know what set

of data or information was searched to get to this fact. Do you?

A. I just told you - I'll repeat it again - that the multi-agencies that were involved included EMS; they included state Medicaid agency; they included behavioral health providers; they included medical examiners; they included, you know, Controlled Substances Monitoring Program; Board of Pharmacy and some others.

And that's where this information from their database would be coming from.

MS. MAINIGI: I think now would be a good time for another short break. How's ten minutes, Doctor Gupta, for us to take a break?

THE DEPONENT: That would be great.

MS. MAINIGI: Okay. Thank you. We'll be back in ten minutes.

VIDEO OPERATOR: Going off the record. The time is 2:16 p.m.

(A recess was taken after which the proceedings continued as follows:)

VIDEO OPERATOR: Now begins Media Unit 3 in the deposition of Rahul Gupta, M.D. We're back on the record. The time is 2:31 p.m.

BY MS. MAINIGI:

Q. Doctor Gupta, I'm going to show you Statement No. 3, Bullet No. 3 of Exhibit 58.

MS. MAINIGI: Steve, could we scroll down to it, please?

MR. RUBY: Yep. There's a little lag here. Sorry.

MS. MAINIGI: Sorry.

Q. Okay. Doctor Gupta, why don't you take a moment and read that? Let me know when you're ready.

A. Okay.

Q. Okay. Statement 3 reads, "There is a direct correlation between diverted prescription pills and the transition to using street drugs such as heroin, fentanyl, methamphetamine, etc." Do you agree with this statement, Doctor Gupta?

A. Yes.

Q. And what is your basis for this statement?

A. Well, it's both the literature that exists to support that as well as my experience and the opinions that have resulted from my experience.

Q. Okay. Can you give me specific literature references that would support that statement,

Statement 3?

A. Sure. You know, as -- I think back as 2014, Theo Cicero actually published a 50-year analyses in general psychiatry that showed that, you know, as much as 75 to 80 percent of the transition that was happening in people who were using heroin was actually -- they were the people that were in fact looking at -- nowadays, were transitioning from prescription drugs, as opposed to the '60s where 80 percent of people were going in the opposite direction.

So there's been a lot more literature since that that shows about 80 percent of the people that use heroin today have had their start from prescription opioids to begin with.

Now, having said that, we saw very similar facts in West Virginia. We started to see people that were often - because of a large volume and diversion that resulted often in addiction were utilizing prescription drugs, and as there was more policy and actions that were being taken to address that - part of that was reduction in supply - these people really often, as an example, when there was action on shutting down a pill mill, there were

often people that would then not have a supply.

As a result of that, they would either have two or three options. One option was to go to the emergency room. We saw flooding of the emergency room.

Second was to go to street drugs which were much more readily available, cheap in terms of heroin, or just die, overdose and die.

And we were seeing all of this. So our findings matched what was being published. In fact, there's been some work done by Sarah Mars in Philly population that also showed very similar numbers, and we were matching that up.

So as that began to happen, more and more people transitioned to heroin, there began an infiltration of cutting heroin with fentanyl by drug dealers primarily to save costs, to make more money.

And as that was happening, fentanyl, of course, is a substance that's about 80 times more potent than morphine, so because it was uncontrolled, we were seeing batches of deaths happening together because of bad batch of fentanyl-cut heroin.

Across West Virginia, that was the case. When we had in 2016, fall of 2016 or so, an outbreak in Huntington, West Virginia that was first but not the only of its kind across the country, where in a matter of hours, dozens of people were overdosed and had to be taken to the hospital.

This was an example of where disease from overdose was starting to simulate an infectious disease, meaning you have a patient zero and -- or -- which would actually be a drug dealer that would have a bad batch, and that many people would get impacted.

Same thing happened in Beckley during my tenure, and other places as well.

So that -- that first phase was prescription drugs. The second phase, because of increased volume -- the volume, diversion and addiction was actually getting it on.

And the action that followed was to transition to heroin. That was wave two, as CDC describes it.

The third wave was actually mixing of heroin with synthetic opioids like fentanyl, and I

truly believe we're in the fourth wave. The fourth wave now, in the last few years, has been that there's a trend now to utilize not just a -- one type of medication, but also a combination of medications.

So now, the same population described as (Zoom audio glitch) is transitioning to polysubstance use, meaning oftentimes we're finding now the pills have not just meth, but also fentanyl in it. And the combination of people using heroin, fentanyl, and methamphetamine and cocaine, that means stimulants and depressants at the same time, is -- is, you know -- is evolving at this point.

And there's been data that has shown -- for example, Chris Jones at CDC, has evaluated data published from 2015 to 2018 data that looked at, and 40 percent of those people who used meth, crystal meth, in the past year utilized prescription drugs, prescription pills, prescription opioids.

So that's been important. And we also know through some of the work with Beth Han at JAMA Psychiatry that was also published that showed the overdose death rate has now gone five times, five

full increase, because of meth.

So we're seeing a lot more carnage on the streets, certainly in Cabell County, Huntington, West Virginia, not very dissimilar than other parts of the country, where we are seeing this transition of prescription pills to drugs like heroin, fentanyl and now meth and cocaine.

And one of the problems we're seeing also as a result of that is because when we went from pills to IV drug use, which is heroin and fentanyl and often sometimes meth as well, we're seeing the increased risk of communicable diseases such as HIV and hepatitis.

So that's one of the reasons we've had outbreaks of HIV in West Virginia and other parts of the country as well, because of increased use of needles and syringes that ultimately emanates from the prescription pill volume.

Q. Okay. Let me stop you, Doctor Gupta, then and dissect some of what you've said at least. You mentioned JAMA Psychiatry -- was there a specific -- I missed the very first thing you said. Was there a specific study from JAMA Psychiatry that you referred to? That's the only question on the

table right now.

A. The first study I mentioned was from Theo Cicero in JAMA Psychiatry in 2014.

Q. Okay. Thank you. Your experiences in West Virginia, did you document those experiences anywhere?

A. I'm not -- I'm not sure what you mean. You can see -- I guess --

Q. You told me about your experience, right, in West Virginia? And I don't need that recapped. I heard it. Did you document that in your own study or paper, for example?

A. I -- as Commissioner, I would have provided interviews to media outlets, and you're welcome to search the databases to review my views, my opinions and my experiences in the public domain.

Q. Okay. You mentioned Sarah Mars who described the Philly population. Do you recall doing that?

A. Yes.

Q. I take it that Ms. Mars documented somewhere some sort of study related to the Philly population. Is that right?

A. As a researcher, yes.

Q. Okay. When you designed the first phase, which is the phase related to prescription opioids, what's that general time period that you're defining that first phase?

A. The general time period would have been from the beginning of 2000s to about 2010 or so.

Q. Okay. And then the second phase, which is the move to -- is the move to meth and heroin and other illegal substances; is that fair?

A. No. Actually, the second phase is actually when we transitioned to heroin, which would have been mostly around the time from about 2011 to 2015, with, of course, significant overlaps, because one doesn't purely transition to the other, but there would be overlaps, because 2010, '11, as we began to enact policies, programs and regulatory actions that would help us downstream reduce the volume of pills, there was transition happening into the street alternative, which is (audio glitch).

Q. And then the third phrase you define is what period of time, approximately?

A. So that would be roughly from 2015 onwards when not only it was just heroin and prescription

pills that was ongoing, but the addition of heroin being cut with fentanyl.

Q. The -- coming back to your experiences, just to confirm, I'm not aware of any statistical analysis or sampling that you did with respect to this Statement No. 3 that we're talking about. True?

A. The reports are there, Ms. Mainigi, for you to look at. I'd be happy to share with you all of the data. But it is also my opinion that this was happening. So we have the reports, and we have my opinion.

Q. Okay. And the reports that we're talking about primarily are the two reports that we've spoken about, the autopsy report from 2016 and then the 2000 to '15 report?

A. They wouldn't be the only reports. They would be helpful, but during my time as Commissioner, we provided to the public very regular reports of all overdose deaths and the trends and analyses that happened and that were happening across the state, including in Cabell County, including in the City of Huntington.

We were providing those pretty

frequently and regularly to the public. I would encourage you to look at those as well.

Q. Okay. Well, tell me where I can find the specific data relating to Cabell and Huntington as it relates to Statement No. 3 that we've been discussing.

A. Well, the easiest way for you to be -- go ahead and FOIA those documents in the State of West Virginia, and you'll find them.

Q. Okay. And what would I FOIA, Doctor Gupta?

A. You would FOIA as we just mentioned: The reports, trend analyses, the cause of overdose deaths based on counties across the state.

Q. Your statement here notes the correlation between diverted prescription opioids and then the transition to the use of illegal substances. Your use of the word "diverted," is that the same definition of diversion that you gave me earlier in your testimony?

A. When I speak about "diverted," what I really mean, that as we saw the SAMHSA National Survey of Drug Users Health Survey in 2017, about two-thirds of the pills that were there, prescription pills, prescription opioids that were

coming from friends and family, and only about -- I want to say about maybe 5 percent or so that we collect or being sold or something like that.

So about -- it was a rule of thirds. Two-thirds were being diverted from prescriptions from friends, family, neighbors and others; and one third of those were being prescribed appropriately but misused in some way or another.

So I would say that it's the legitimate prescriptions as well as illegitimate prescriptions, and of course, those -- both of those, as we know now, used beyond a period of time they're recommended lead to addiction.

And of course, when we say "transition to street drugs," that means those individuals that are suffering from substance use disorder as a consequence of using prescription pills that are now having to seek alternatives to continue the, you know, managing their disease through street drugs, and that's what I mean.

Q. So the two-thirds, the SAMHSA study that you reference, the diversion that occurs related to friends and family occurs after the prescription bottle has come home, perhaps been somewhat used,

but you've got leftover pills presumably lying around. Fair?

A. The two-thirds approximately on the survey that was reported was often -- were prescriptions, prescription drugs - so we're only talking about the prescription drugs at this point - that people have brought home.

Now, these could be legitimate prescriptions; they could be illegitimate prescriptions.

And -- but if those that are flooding the population because of the large volume that happens. So someone had a -- you know, I use a tooth pulled example. But you could use a cataract example, but something for a one-time event but somebody got 30 days with three refills, well, that's going to lay around and that's going to get into the hand of children -- hands of children or somebody else, for all types of purposes, and that's the diversion.

Now, on the other hand, when somebody gets it for a legitimate prescription and also either goes and sells it or misuses it or gives it to somebody else to misuse, that's also diversion.

So -- and then obviously diversion leads to addiction which leads to the constant need to have some sort of opioids in your system that when those volumes start to shrink, people transition to other types of alternatives.

Q. Now, you are aware, Doctor Gupta, are you not, that the vast majority of people who use prescription opioids do not become addicted to street drugs?

A. I'm sorry, could you repeat that, please?

Q. Sure. Do you agree that studies demonstrate that the vast majority of people who use prescription opioids do not become addicted to street drugs?

A. We're talking about two very different populations, so I'm not sure of the correlation. Are you talking about -- I need to have more data on that.

Q. Okay. In your experience then, as a practicing physician as well as the various roles you've held in West Virginia, do you agree that the vast majority of people who use prescription opioids do not become addicted to street drugs?

A. What time frame are we talking about? I'd

like to -- you know, like I said, I'd like to know more about that.

Q. The time frame that you held the positions in West Virginia that we've been discussing.

A. That's not what I'm asking you. I'm asking what -- for what duration of prescription opioids do those people use, and for what purpose? Because context is important.

Q. During the -- the vast majority -- do most people use prescription opioids for long-term periods?

A. So in 2012, United States, we had 255,000,000 prescriptions. That was 80 prescriptions for 100 people across the country. I hope that answers my question -- your question.

Q. Well, why don't we -- so you don't have -- I'll just ask you one more time. You -- from your experience, you don't have an opinion on whether the following statement is true or false. The -- and the statement is: "The vast majority of people who use prescription opioids do not become addicted to street drugs."

A. According to the 2016 March guidelines for chronic pain from the Centers for Disease Control

and Prevention, use of prescription drugs, opioid prescriptions, for more than five or seven days, puts you at a very high risk for addiction.

Q. For addiction to that prescription drug, correct?

A. For addiction -- for the disease of addiction. Period.

Q. Let's go to Statement 4. Why don't you take a moment and read it.

A. Okay.

Q. Okay. Statement says, "Once an addiction is formed, an individual struggling with addiction will obtain the addictive substance by any means necessary, which often results in illegal activity and the use of illegal substances."

Do you agree with that statement?

A. Here's what my opinion is: I believe that once someone is suffering from substance use disorder, that individual is struggling with a disease, is -- has a actual chronic relapsing disease, and it becomes then very important that that individual is offered the help in order to treat that disease, just like we would do for diabetes or cancer or anything else.

Going untreated, there are a number of risks to that individual that include all the way from -- from suffering from disease, other mental health conditions, to all the way to death.

Q. Doctor Gupta, I'm going to explore some of what you just told me in a minute. But before we do that, can I just ask you to look at statement -- the statement that's marked 4 and tell me whether, as written, whether you agree with it or disagree with it.

A. I'm not sure I have an opinion about that statement, the way it's written.

Q. Do you know what percentage of people struggling with addiction do illegal things to support their addiction?

A. I don't have a percentage at this time.

Q. Do you know what percentage of people who become addicted to prescription opioids go on to use other illegal substances?

A. From the data that I've highlighted prior, it's -- what we know now is about 80 percent of people who are using heroin got their start from using prescription opioids.

Q. That is not the question I asked. Right?

A. That is the answer.
Q. What percentage -- I'm sorry?
A. That is exactly the answer I provided, so --
Q. That's the only figure that you have then. Fair?
A. Well, I'm happy to rephrase it if you have -- you know --
Q. Well, let me ask you the question again, just in case I misunderstood your answer. Can you tell me what percentage of people who become addicted to prescription opioids go on to use other illegal substances?

So this is the percentage of people who become addicted to prescription opioids.

A. So to my previous statement, I think by phrasing the question the way you have, you're discounting the thousands of West Virginians and hundreds of thousands of Americans who have actually perished as a result of addiction, and I think it's an unfair question to ask that way.
Q. Okay. I will take from your answer that you don't have a number, Doctor Gupta. Let me move on to your Statement No. 5, if I could. Let's move

that up here so we can see it.

Statement 5 reads, "The IV drug use problem in Cabell County and the City of Huntington is an evolution of the prescription drug problem." Do you agree with that statement?

A. I would say broadly, yes.

Q. And you're not a specialist in IV drug addiction, correct?

A. I'm an internist, as we made clear, with public health expertise as well as in a number of areas, so I'm not sure what you're referring to, if that specialty exists.

Q. Did you do any sampling for statistical analysis as it relates to Statement No. 5 in Cabell County?

A. Once again, I would refer you to state, to county -- county analysis we have for both the prevalence of disease as well as others that we regularly provide in the analysis.

You might find that, actually, some version of that in the 2015 report.

Q. Okay. Sitting here right now, are you aware of a specific analysis in Cabell County that correlated the use of prescription drugs and then

subsequent IV drug use?

A. I would love to take a peek, but you won't let me, into these reports. So I'm handicapped in the way I'm answering my question -- your questions.

Q. Okay. But sitting here right now, no specific report that you commissioned is coming to mind, Doctor Gupta, that would allow me to see that correlation?

A. Ms. Mainigi, I mentioned there is a report, but you're not going to let me see it, so what's the point?

Q. Which report?

A. The 2000 to 2015 analyses.

Q. Okay. I will see if I can look at that on the next break. But we are time limited here, so that's -- that's part of our problem. But you think if there's an answer, it would be in the 2000 to 2015 analyses.

A. That would be one of the areas to go into. And I've given you a number of other potential ways and means to get there if you wish to.

Q. Now, when you use the word "an evolution" in this statement, No. 5, are you referring back to

the different phases that you went through with me, the fact that you think Phase 1 is prescription opioids and then that went to heroin as Phase 2 and then a subsequent Phase 3 and Phase 4?

A. Yeah, basically the recognition that, you know, the prescription drug was a sentinel event, the volume, that has led to such the complexity and evolution of the problem in a way that now we're almost circling back to where we're finding more and more prescription drug supply that is being contaminated with fentanyl, in fact.

So it started from pills; it's now coming back to pills in some areas of the country.

Q. Now, it's not the case, is it, that all use of IV drugs is caused by prescription opioids?

A. Yeah, so in the data I mentioned -- which is, again, broadly agreed by all the experts. I don't know if there's any IV drug use experts in the nation, but clearly the experts that I work with as an expert with those across the nation, it is very broadly agreed that about 80 percent of the heroin users have started their -- with prescription drugs.

That would, of course, leave the 20

percent that may have had different reasons or other reasons to do that. So that just does leave that 80/20 rule to -- to consider.

Q. And I think the number -- but I don't want to go round and round with you on it. The number I'm saying is -- is it -- so do you think 80 percent of IV drugs -- drug use is caused by prescription opioids?

A. The evidence suggests that, you know, 8 out of 10 people who are using heroin right now. And my opinion to a reasonable degree of certainty is based on that for Cabell County from the -- for the City of Huntington and for the State of West Virginia.

Q. Okay. And 8 out of 10 -- your opinion is that 8 out of 10 Cabell County heroin users what? Finish out your opinion.

A. Began their journey to developing addiction - substance use disorder, in other words - from -- and got initiated from prescription opioids.

Q. And by "prescription opioids," you include in that prescription opioids that they may have diverted from someone else. Right?

A. Yeah, so we include legitimate prescribing;

we include illegitimate prescribing; we include diverted in the sense of borrowing, stealing, purchasing, all of those things.

Q. Have you done any independent analysis - besides relying on this study that you referenced - to determine if this 80 percent number is applicable to Cabell County?

A. As I've stated, that's my opinion to a reasonable degree of certainty.

Q. And my question is: Have you done any independent research to determine if that 80 percent number is applicable to Cabell County?

A. I can't recollect at the time, so I can't say yes or no. I just don't -- I don't remember at this point.

Q. And do you remember whether you did any independent research in the City of Huntington to determine if that 80 percent number is applicable to the City of Huntington?

A. No, I don't think I -- I can't recollect. But also, you know, we have 55 counties in the state, first of all. Second, there was an outbreak of overdose, and I can't recollect at this time the exact findings of the outbreak in 2016.

So that's another resource for you to go and look at if you -- if you're willing to.

Q. By the way, the 80 percent number that you cite, what study does that come from?

A. That's -- a number of people have done that. So the Theo Cicero, as I mentioned, JAMA Psychiatry. It's something that has generally been accepted. You know, I can help -- I can provide you the specific resources. But Theo Cicero found, I think, about 75 percent.

And I think most -- most of the data has usually quoted 80 percent.

Q. But you recall -- the one you're specifically recalling is Cicero.

A. Yeah. Cicero had 75; I think Sarah Mars may have 80. But that's an agreed-upon -- and I want to say with a reasonable degree of certainty that CDC utilizes that number as well.

Q. The CDC uses that number as well. Okay.

A. Yeah. I -- I want to say -- again, I'd have to -- if I was allowed to look at it, I would look at the stats. But you know, we're not in that phase right now.

Q. And what stats would you be looking at

besides the ones you've mentioned, Doctor Gupta?

A. I would be confirming my statements that CDC numbers --

Q. Let's shift to Statement 11, if we could. Why don't you take a moment and read that.

MR. RUBY: This spans two pages, Doctor, so let me know when you're ready to --

THE DEPONENT: Okay. Go ahead, please.

MS. MAINIGI: Steve, there's no way to get both pieces in?

MR. RUBY: Let's see. We might be able to shrink it. There we go.

MS. MAINIGI: There we go. You're such a pro, Steve.

BY MS. MAINIGI:

Q. Okay, Doctor Gupta, Statement 11 reads as follows: "Although there was a 15-20% reduction in opioid prescriptions in 2015 and 2016, there was no reduction in overdose deaths because the addiction had already been formed and people with opioid use disorder were turning to illicit, more lethal forms to feed their addictions that was initially formed by prescription opioids."

Do you agree with that statement?

A. I would generally agree. I think the change in West Virginia was about 15 percent reduction in opioid prescriptions from 2015 to '16. So with that exception to more like 15 percent, I would agree with that.

Q. Okay. And the 15 percent reduction, I'm assuming that's something that is a statement of fact that's checkable, correct?

A. Yeah. In fact, it's not only a statement. This was the largest reduction in the country of any state. So West Virginia, while I was the Commissioner, not only declined its prescriptions from 2015 to '16 within one year, it had the largest decline of any state in the union.

Q. And the fact that there was no reduction in overdose deaths in that same time period, that's also a statement of fact, correct?

A. That's a statement that goes back to Phase 2, as we discussed. So this is -- this statement is very much indicative of my opinions being formed about the Wave 2, basically.

Q. Okay. Well, let me focus just on the statement, not the correlation between those two

statements. The statement that there was no reduction in overdose deaths in the same time period, 2015 and 2016, that's a checkable fact. Right?

A. Right.

Q. Okay. And I assume that -- do these statements come from your autopsy -- the 2016 autopsy report?

A. Again, Ms. Mainigi, you won't let me look at it. How can I tell you that?

Q. Now, the data that made up the 15 percent and the data that made up the overdose -- no reduction in overdose deaths, you didn't compile any of that data yourself, correct?

A. As a commissioner, I, once again, oversaw/directed/supervised, authorized the chief medical examiner to both analyze as well as put together, as well as my epidemiology team, from my instructions, to look at the overdose deaths.

As far as the prescribing data, that did not come from the Bureau for Public Health. So I cannot speak to the prescription data because that was not within the prerogative of the Bureau for Public Health, but I can speak to the overdose

deaths data because I was directly in oversight of that data.

Q. Can you tell me, Doctor Gupta, what percentage of people in Cabell County in this time period who were prescribed opioids later used illicit drugs?

A. I don't have that number with me right now.

Q. Do you have it anywhere?

A. I wouldn't know. You wouldn't let me look at anything.

Q. Well, where are the places you would go to find that number, Doctor Gupta?

A. I would look at publicly-available data, reports.

Q. Besides the two reports that we've spoken about, what other reports would you look at?

A. I would look at any other public reports that are available; I would again go back to and ask the State of West Virginia to provide that data if you so desire.

Q. Is that your position, Doctor Gupta, is it, that everyone who's prescribed opioids later uses illicit drugs?

A. That's absolutely not my position. In

fact, as I had asserted today, is the problem began to evolve because when the efforts of regulators, policy makers and others to -- in a downstream way, to limit the volume of the pills that was coming from upstream and drowning our communities, including City of Huntington and Cabell County and the rest of the state, we were doing what we could to limit the volume. And part of that volume limitation was to put in practice various regulations as well as education activities as well as enforcement activities.

The consequence, unintended consequence of that when this was happening, is that people were transitioning because by no fault of theirs, they were suffering from what you may know as addiction, we know as substance use disorder.

And substance use disorder is actually a disease. It's a chronic relapsing disease, that people are the victims of the disease. As these victims were suffering from a disease, they had to find other sources of opioids, so they transitioned on to the street alternative, as a result of which they began to use IV drugs in terms of heroin and

ultimately would die because of overdose, especially because of the surge of the cutting of that heroin with fentanyl.

So you know, it all depends where those clinics were being shut down, where more physicians and other prescribers were reducing the supply, meaning writing fewer prescriptions, and where there were, you know, less diversion of the volume.

That's what was happening more, meaning in terms of transition to heroin and fentanyl.

Q. What were the efforts -- just at a high level, what were the efforts that were made by you and your colleagues to reduce volume?

A. So prior to my coming into the office, there were legislation that required mandatory educational training in terms of CMEs for all prescribers for opioids.

There were more regulations of the CSMP, the State's PMP, to be able to interrogate every time you are wanting to prescribe an opioid.

There was more focus on ensuring that there was Good Samaritan Laws. There was more

available giving of naloxone. There was another look being taken at medications to assist in therapy, treatments and things like that.

When I came in, clearly we looked at this number, the social autopsy that you -- you've discussed today, and we really put the legislation in the next year through what we called Opioid Reduction Act.

I believe it was Senate Bill 273 in the legislative session of 2018, to limit the initial prescribing to about four days unless there were reasons to -- not to.

Also in 2016, as soon as the CDC's guidelines came out for chronic pain, Governor Tomblin became one of the first governors in this country to adopt uniformly the pain guidelines and we worked very closely with our insurance providers as well as our prescribers to do what they could to adhere to those pain guidelines for -- or for chronic pain guidelines.

So these are just some of the efforts. We did make naloxone available, but in terms of just reducing the volume, these are some of the efforts that we were doing.

Q. And the efforts were directed to helping physicians manage the standard of care for treating pain which had evolved in the early aughts, fair?

A. Yeah, I wasn't -- yeah, I mean, we had a standard of care in the 2000s and late '90s which actually treated pain as a vital sign. The HCAP surveys from AHRQ were still in place that -- you know, that incentivized hospitals to be asking those questions about pain.

So we were swimming upstream against the wave in order to limit the volume where pain was still the fifth vital sign.

And often incentivizing hospital care to -- you know, to look at satisfaction -- patient satisfaction rather than treatment of pain adequately.

So we were working against that wave to ensure that our physicians across the state understood what legitimate good prescribing looked like, what -- what made sense to make sure that we were prescribing for legitimate pain, nothing else.

Q. Now, I think you described in your prior deposition the reasons for the change in standard of care that the doctors provided in the -- in the

late '90s, early aughts. One was an ethical reason, the doctors had an ethical obligation to reduce patients' pain down to zero. Is that fair?

A. I don't think I said that doctors -- I said the manufacturers, you know, and others created a system or an environment where physicians were made to feel that there was an obligation to bring everyone's pain down -- across America, down to zero level.

And the pills that we were provided should be provided liberally, and there is no problem, there's no addiction, there's no side effects of those pills.

So that was a -- that was a -- the effect that was created. Purposefully, now we know.

But -- and clearly organized medicine was engaged in that.

Q. And so the efforts that were made in West Virginia in 2015, '16, '17 were to help counter balance that through the physician population.

A. The efforts were to educate prescribers - not just physicians, all prescribers - for Schedule II to ensure that they understood what good

practice guidelines are for pain. They understood the risk of addiction, especially with longer -- higher doses and longer durations, and they were more judicious in prescribing.

And for those who already were suffering from substance use disorder were able to seek the help that they could so they do not overdose and they do not die.

Q. Let's switch gears to Statement 19, Doctor Gupta. It's --

MS. MAINIGI: Let's scroll down to that.

A. Okay.

Q. That statement reads, "Addiction tells people to seek opioids in one form, shape or other." Do you agree with that statement?

A. I would -- I would say it this way: It's my opinion that substance use disorder makes people seek substances to continue to feed the habit because there's a constant need for Dopamine in the -- in the brain.

So -- and then people would do - in the grips of addiction - as a result, what they need to do to continue to seek those substances.

Q. What is your basis for this opinion, Doctor Gupta?

A. The basis for my opinion is my training in medicine; my experience, 25 years of practice of medicine; and with a reasonable degree of certainty, as well as my understanding of the science of addiction and substance use disorder.

Q. Do you have any research papers that you can cite to me as support for this statement?

A. Sure. You can probably -- there's a PBS documentary on Nova called "Addiction." They have featured the director of the NIDA, National Institute of Drug Abuse, a few addition -- an addiction psychiatrist and myself, to talk about addiction.

And you're welcome to see that. That's kind of one aspect. But then I'm happy to get you textbooks for addiction or papers or otherwise. But this is the -- the science of addiction, while developing and evolving, this is what we understand today in medicine.

Q. Now, you are not an expert in addiction psychiatry, correct?

A. That's correct.

Q. You're not an expert in neurobiology?

A. I don't know what that expertise is, as I said before.

Q. Let me go back to one of the things -- one of the statements we were discussing previously, Doctor Gupta. When there was a reduction in the levels of opioid prescriptions in the 2015-'16 time period, were you surprised? Were you and your colleagues surprised that heroin overdoses increased?

Had you anticipated a decline in drug overdoses as the prescribing levels dropped? Or was -- was that something that did come as a shock to you?

MS. KEARSE: Objection.

Q. Let me -- let me ask the question again to avoid objection. You referenced a reduction in the levels of opioid prescriptions in that '15-'16 time period. Correct, Doctor Gupta?

A. Yes.

Q. When you saw the reduction in opioid prescriptions in that time period, were you surprised that heroin overdoses increased?

A. So we know again that opioid prescribing

was primarily, across the nation - and certainly across West Virginia - was being done by primary care physicians like myself, not addiction psychiatrists, by the way, not neurobiologists, but primary care physicians.

And we also knew that to change behavior, it's going to make -- take a lot of effort for -- to change the behavior of those primary care physicians. But we also knew that we may or may not be able to see immediate gains of that.

And what happens with a basic tenet of public health, that A plus B does not always equal to C. We do not always have one-to-one cause.

You're always working with associations in mind. That's what epidemiology is, what epibiostats is. That's what public health is. So you're never surprised.

We're not surprised at the HIV outbreak that was happening because heroin use has increased. So what we wanted to do in public health, as a public health expert, was to -- first and foremost, we have to turn off the spigot somewhere, and turning off the spigot meant

starting to make progress and reduction in the overwhelming volume of prescription opioids that was flooding out communities.

Now, what's the consequence? We knew it was not going to be a straight line. Whether people who are once suffering from substance use disorder will go on to the next as a transition because they can't get away from their addiction or their -- not enough ability for the system to accommodate that level of addiction? We knew that.

So when we saw the transition to heroin and then fentanyl, it's not a matter of surprise; it's a matter of: This was the next wave that was oncoming, and we have to figure out how to address that.

So you know, we don't get surprised in public health. What we do is: We're always working to address the root causes of the problem and then manage the consequences of the actions, and that's what we've been doing since that time.

Q. Let me ask this way. That's -- that's a very good explanation. When you reduced levels of opioid prescriptions in this 2015-2016 time period, I take it you didn't predict that one of the

results would be an increase in heroin overdoses. Correct?

A. When you have a high level of addiction in society because of prescription opioids, it's almost a foreseeable consequence that things will evolve. So while I can't guarantee you it was going to be heroin or just fentanyl or meth, it was very clear that we're going to have to deal with this consequence for decades to come in the future.

So the way I would answer is that this was pretty foreseeable when we were addressing it. But that didn't mean that we would not act to reduce the volume.

Q. What was foreseeable by you --

A. That --

Q. -- in 2015-2016?

A. That we had a higher level of people who were suffering from substance use disorder, and we have to make sure that as we're reducing the volume of prescriptions, we have to figure out to make sure that they're getting the help they need.

But in our communities, you know, we didn't have the -- have the aspect of the health that we needed at the time in terms of treatment,

in terms of reduction in stigma, in terms of prevention of HIV outbreaks and other things.

And we began to see people transitioning off to the cheaper alternatives. We just didn't know which alternative at the time. But it was foreseeable that --

You know, when you have somebody with -- suffering from substance use disorder or addiction, you know, what do you expect? It's the same thing. I mean, if you, you know, put a fire in a house full of, you know, liquid oxygen, what do you expect? It's gonna blow up eventually.

And that's kind of what's happened to our community.

Q. As the State Commissioner of Health at the time, did you take any action to avoid what was foreseeable in your view?

A. Yes. So we began to ask more screenings for communicable diseases in juvenile centers, correction centers, treatment centers, other places, local health departments. We increased surveillance efforts; we increased vaccination efforts for Hepatitis, as an example.

So we enhanced every aspect, because

we knew that once this was starting to happen, consequences will happen.

We also, at the time, worked closely in - I would say - 2017-2018 with federal DEA as well as the law enforcement officials to make sure when the crackdown was to happen, that my office would be involved ahead of time.

So one of the things we did was: We were the -- only the third state in the nation behind the state of Washington and Maryland to create protocols to engage with federal law enforcement prior to a crackdown on a pain pill -- pain clinic, pill mill.

The reason that was important was: They describe when a clinic gets shut down, let's say there's 800 patients, nobody in the community - no other physician - will take them, because nobody wants to be labeled as taking patients of Doctor X.

Now, on one hand, I was the secretary of the Board of Medicine that was actually, you know, working through a disciplinary process for that Doctor X and also realizing that nobody else was gonna step up because they're afraid of their license being in trouble.

So we created protocols where via doctor letters would go to in that area or that county before a pill mill was about to be shut down around that time.

We created educational resources. We created all of these protocols. So we were working closely with federal, state and local law enforcement behind the scenes so that when that action took place, you didn't just see police officers and people being taken to jail, like bad doctors and their staff.

But then we worked behind the scenes to make sure those people would have resources to go to so they don't end up being on the street and using IV heroin. They don't end up flooding the emergency room or they don't end up, worse enough, dying.

So those are the actions that we took.

Q. I'm going to ask you to move to Statement 20. Statement 20 reads, "Chemically speaking, synthetic opioids, semi-synthetic opioids and the prescription opioids work through the same receptors and feed the same need to the body." Do you agree with that statement?

A. Yes.
Q. You're not an expert in addiction sciences, you've already said, though, correct?
A. I'm not an addiction psychiatrist.
Q. Have you done any research on the effects of various opioid substances on the brain?
A. I've not conducted any lab research on the effects of opioids on the brain.
Q. Let's go backwards to Statement 12. Statement 12 reads, "The increase in overdose deaths in West Virginia during that time was caused by the large volume of opioid pills that were originally deposited or delivered to West Virginia."
Do you agree with this statement?
A. That is my opinion.
Q. What is the time period that you would agree that this statement is true?
A. I would say at the beginning of 2000-2001 to date.
Q. Now, you don't mean by the statement that prescription opioids were the sole cause of the increase in opioid deaths, do you?
A. Could you repeat that, please?

Q. Sure. You don't mean by this statement that prescription opioids were the sole cause of the increase in opioid deaths, do you?

A. If I heard you correctly, you said, "the prescription opioids were the sole cause of opioid overdose deaths." Is that what you're asking me?

Q. I'm asking you whether you think that prescription opioids were the sole cause of the increase in opioid deaths.

A. Prescription opioids were a substantial factor in the significant rise in overdose, drug overdose, deaths in West Virginia.

Q. Now, was the criminal distribution of heroin a cause?

A. Heroin certainly -- heroin cut with fentanyl was also a cause. But just to remember, that was driven from prescription drugs, prescription opioids, transitioning.

Q. What are some of the other causes?

A. So there's often not a one-to-one relationship. What that means is, what we were finding, that an average decedent had anywhere between three and five substances in their body. What would they be? They could be

prescription opioids; they could be benzos; they could be fentanyl or heroin. So those were some of the substances in that time frame of, you know, 2015-'16. And then we began to see meth as well.

Q. Now, besides just the drugs, were there any causes that you studied in your role as State Health Commissioner? For example, a propensity to addiction?

A. So the Office of the Chief Medical Examiner which I oversaw is a centralized medical examiner's office in the state which sees all of the deaths that happen from -- you know, within that statute that's required. So the drug overdose deaths are one part of it. So we're talking homicides, we're talking other aspects of deaths.

So there were other deaths also that happened that we track and follow.

Q. Did you look at the propensity for someone to be addicted?

A. Are you speaking about the 1.8 million people in West Virginia, to look at their propensity?

Q. Well, just generally the propensity of someone to have an addiction. Did you look at

those types of issues, other than whatever drugs were in their body?

A. We just follow science, and in science, so far we know is that you're not able to predict but you know that -- you know that if someone is prescribed opioids for beyond five or seven days, the likelihood of suffering from substance use disorder is much higher.

So we know that. In terms if you're asking, are we doing studies with genetics or other aspects? Not at the Bureau of Public Health.

Q. Coming back to the issue we were discussing before, you know, what you were anticipating after prescription opioids -- prescriptions for opioids was decreased, do you remember noting somewhere publicly or telling anybody publicly that you anticipated that there would be consequences such as an increase in heroin overdoses or anything of that sort?

A. I mean, you would have to search my public record. Clearly, we were not the only state in the union. There were other states that similar patterns were happening and we were recognizing that. And we were anticipating that this would

happen because it was happening other places.

So this was a trend that was happening across the country, not solely and exclusively in West Virginia.

So it would be reasonable at that time to form an opinion based on the findings of my colleagues across the country.

Q. Let me switch over to Statement No. 17, Doctor Gupta. Statement 17 are -- is "NAS babies are a causative issue in terms of the opioid epidemic." Do you agree with that statement?

A. I actually don't understand that statement very well, so if you -- I mean, I can say my opinion is that --

Q. Well, let me interrupt you, because our time is getting short and I apologize.

A. Yeah.

Q. But I'm just asking you right now whether Statement 17 is a statement you agree or don't agree with.

A. I would generally agree broadly.

Q. Okay. Broadly. So does this statement mean that the incidence of NAS, that neonatal abstinence syndrome has increased as more opioids

were prescribed?

A. Yes.

Q. So that's a matter of fact, not opinion. Right?

A. That's both a fact and an opinion.

Q. Well, it can be empirically proven, correct, whether it's true or not true?

A. It can be proven, and it also goes along with my experience as a physician and having to visit the neonatal ICUs across the state of West Virginia and neonatal ICUs across the country that I see that.

Q. And other than what you saw anecdotally across the country and across West Virginia, was there some sort of systemic research or information compilation that was done by your department on this issue?

A. Absolutely.

Q. What was that?

A. We, first of all, created a clinical definition for NAS that we had all the birthing facilities in the state of West Virginia, including Cabell County and City of Huntington's hospitals agree to.

And all of the doctors - meaning the birthing physicians in Cabell County and all across West -- across West Virginia, agreed to a common definition. Once we did that, we then started to capture that definition and those diagnoses in a program called Birth Score out of West Virginia University.

We worked very closely with experts in Marshall, at Marshall University, to measure the amount of NAS that was happening. And I'm using NAS intermittently with NOWS, which is neonatal opioid withdrawal syndrome, and we then characterized the rate of NAS per county, and we found that the average rate of NAS in the state was 5 percent. That's 1 in 20 babies, which is the highest by far of any state in the nation.

But we also found that some of the counties had much higher rate, to the tune of 10 and over 10 percent. Again, that's a published report, available in the public domain. And I -- I don't have a -- you know, a lot of recollection about every aspect of it.

Q. Do you remember who within your organization primarily did the research for that

report?

A. It would have been the -- under my supervision, the Department of Family and Children's Services.

Q. Statement 21. Let's turn to that for a moment. "Children diagnosed with at birth have noticeable difficulties learning and paying attention." Do you agree with that statement?

A. Once again, diagnosed with NAS is what's missing here, but if we could put "with" blank, because that's just -- it's an error in the statement.

Q. Okay.

A. So -- yeah.

Q. So with that "NAS" added, do you agree with that statement?

A. Yes.

Q. Now, you don't have any training in neonatology or pediatrics, correct?

A. Actually, I have had rotations during my training in pediatrics and neonatology.

Q. When you were a resident; is that correct?

A. When I was in medical school, and I don't remember if it was residency too. But I've also

done emergency room coverage that included -- as well as my primary care practice, that included children.

Q. Okay. And that includes neonatology as well?

A. I have not taken care of NICU babies, so no.

Q. Have you done any research on the incidence of attention or learning deficits in children diagnosed with NAS?

A. Not personally, I have not.

Q. Do you know what percentage of children diagnosed with NAS exhibit noticeable difficulties learning and paying attention?

A. We are just at the precipice and that data is evolving, so I can't tell you for certain what that percent is.

(Background noise.)

MS. MAINIGI: If someone is off mute, could you please go on mute? I hear some background or interference. Is there a --

MS. KEARSE: Someone needs to be put on mute.

(A discussion was had off the record

after which the proceedings continued as follows:)

BY MS. MAINIGI:

Q. Doctor Gupta, do you have any studies or reports that would support the statement in 21 that you --

A. Yes.

Q. -- can give me?

A. Yes.

Q. What are they?

A. There's a number of reports, including -- if you go to the CDC website, and that clearly talks about some of the challenges in learning as well as memory development, cognitive development as a consequence of NAS.

Q. Now, can you tell me what percentage of NAS diagnoses result from prescription opioid use versus illicit opioid use?

A. Once again, very similar to people who die and you cannot tell in them because the metabolites are the same. To the developing baby, it doesn't really matter whether it's prescription or otherwise, so --

What I can tell you is: We did

studies in West Virginia at Bureau of Public Health and we found that one out of five babies' cord blood had a substance positive. That was with -- that was inclusive of prescription as well as illicit.

We also found that almost 15 percent of intrauterine exposure was positive for substances. And I believe that was prescriptions.

But once again, I don't have access to that data right now, so I cannot be 100 percent certain at this point.

Q. The one-out-of-five statistic, was that something that was published by --

A. Yes.

Q. -- by who?

A. We have published that. So the first study was published by -- by one of the neonatologists - we funded the study at CAMC - Doctor Stefan Maxwell.

Q. 22, "As children with NAS enter the classroom, there will be noticeable, interruptive and impulsive behavioral issues." Do you agree with that statement?

A. Yes.

Q. Are you making that statement as a mental health professional?

A. I'm making that statement as a Commissioner who has interacted with hundreds of teachers, school board members and parents and has learned a lot through interacting with actual West Virginians on the ground.

It is my opinion with a reasonable degree of certainty that children, as they're growing up who are diagnosed initially with neonatal abstinence syndrome have a significant difficulty oftentimes with impulse control, with focus in classroom issues and may sometimes get misdiagnosed as ADD.

Q. Do you -- besides your own experience talking to teachers and so forth, do you have any studies that you can cite to?

A. Yes. So there's a lot of literature. I'm happy to share with you. Some of the folks that have worked on this is people like Stephen Patrick at Vanderbilt and others. That literature is there and is evolving and includes - which is not mentioned here - some of the birth defects as well of children with NAS.

Q. Okay. And let's go back to No. 8. No. 8 reads, "The opioid epidemic has lead to an increase in the number of children entering the foster care system, rapidly increasing child welfare costs to the state." Do you agree with that statement?

A. Yes.

Q. Now, the foster care system in West Virginia was the responsibility of a different part of DHHR than your office; is that correct?

A. That's correct.

Q. You did not oversee the foster care system, did you?

A. I did not.

Q. Where did -- what's your basis for this statement then?

A. In addition to being the Commissioner of the Bureau for Public Health, as I mentioned before, I'm also -- I was also the State Health Officer. That being, it was my responsibility in that role to be overseeing the -- you know, number of other aspects of the public health system.

So we interacted frequently with and worked closely with -- with the -- that particular department, as well as our parent department, which

is the Department of Health and Human Resources, as I -- and I reported to my boss, which is the Cabinet Secretary.

Now, clearly I was open to looking at the data for the foster care system, and saw and experienced in our budget presentations to the legislature each year that we worked together with the commissioners who create that, and we reported on this.

The Cabinet Secretary is on the record stating in his testimony - where I was present - that about 90 percent of the cost of foster system in West Virginia is associated in some form or other with the opioid crisis or the substance use disorder crisis.

So that's something that is on the record from my boss, and of course, it's my opinion based on that and some of the budgetary and other factors and working closely with the -- my co-agency, that this statement holds true with a substantial -- and again, a reasonable degree of certainty.

Q. So opioid prescription medications require a prescription; is that correct?

A. Not always. As we discussed, that people do not need to have a prescription in order to have access to prescription opioids when -- especially when the volume in a community is overwhelming.

Q. Well, to legally obtain prescription opioids, you need a prescription, correct?

A. Correct.

Q. Okay. You can't buy them over the counter, correct?

A. Correct.

Q. And the prescription must be written by a health care provider who is licensed by the State and registered with the DEA, correct?

A. Correct.

Q. And it must be dispensed by a pharmacist who's also licensed by the State and registered with the DEA, correct?

A. Correct.

Q. And no prescription opioid can leave a pharmacy lawfully unless a doctor decides to prescribe the prescription and a pharmacist decides to dispense the prescription, correct?

A. Incorrect.

Q. And why is that?

A. Because doctor is not the only prescriber. You could have other prescribers as well.

Q. Fair enough. So let me ask it again then. So a prescription opioid cannot lawfully leave a pharmacy unless a doctor or other qualified prescriber decides to prescribe the prescription and the pharmacist decides to dispense the prescription. Correct?

A. Correct.

Q. Your Statement No. 2, let's go to that for a moment, please. "The amount of appropriate prescriptions was dwarfed by the amount of inappropriate prescriptions that were being diverted." Is that a statement you agree with?

A. Yes.

Q. What do you mean by the term "inappropriate prescription"?

A. Prescriptions could be - as I mentioned here, or you can see here - is appropriate prescription. That means there are criteria in which it might make sense to prescribe opioids. In other situations, it may not make sense to prescribe opioids, and in those situations, you know, we would call that inappropriate prescribing.

So getting 30 days of Vicodin for a tooth pull would be an example of inappropriate prescribing. Seeing 100 patients in a day without doing appropriate background, looking at patients, understanding their history, doing a physical exam, is another example of what we consider pill mill or inappropriate prescribing in a large volume.

So these are some of the -- you know, dentists, others that -- you know, I said, cataract, an ophthalmologist prescribing 30 days of prescription, is an inappropriate example.

So that's my -- but someone who has -- is -- has terminal cancer and has exhausted any other options, is on opioids, well controlled, is an example of appropriate prescribing for opioids.

So that's my description between "appropriate prescription" and "inappropriate prescriptions."

Q. You're not an expert in pain management, correct?

A. I have served on some panels in terms of the West Virginia SEMP panel and others. I have provided training and talks to the State-level conferences. But I have not received any formal

training on pain management beyond my residency training and beyond my ex -- sort of expertise of 25 years of managing private care physicians, primarily where we were the ones that were -- became the target of writing these prescriptions.

So that would be my answer.

Q. Your definition of "inappropriate", as I heard it, Doctor Gupta, may include prescriptions that were written legally, correct?

A. Correct.

Q. And it could include, in fact, millions of prescriptions that were written legally, correct?

A. Sure.

Q. And your definition of "inappropriate" may also include prescriptions that were within the standard of care that existed at the time they were written, correct?

A. They may or may not be.

Q. Give me an example of a prescription that you would call "inappropriate" but that was written within the standard of care for the time.

A. So the standard of care did not require -- strike that.

We had ample evidence to demonstrate,

through studies, that opioids do not help control or improve function in chronic pain, yet millions of prescriptions were being written for chronic pain for opioids. That's an example.

Q. And at some point in time, at least, prescribing opioids for chronic pain was within the standard of care, correct?

A. One can argue that, but the fact of the matter is that opioids as a first line of therapy for chronic pain were never standard of care.

So prescribing opioids in high volume, in high doses, high strength, as a first line for chronic pain, without any other alternatives, I don't understand to be the standard of care.

Q. And so what did West Virginia do about that through the Board of Pharmacy, the Board of Medicine or any other institution within the state of West Virginia?

A. Clearly, as I mentioned - I'll go from -- you know, from now to backwards - when the 2016 CDC guidelines came out in March of 2016, we assembled a panel at the Department of Health and Human Resources. We brought together all the experts, including insurers, exec -- you know,

representative prescribers and others, and we adopted the guidelines and encouraged that. That's one action.

Second, we created the SEMP panel pain -- prescribing pain guidelines which I was a part of. That's another one.

We also made sure that there was appropriate trainings that were happening - which I mentioned I spoke at oftentimes - the appropriate prescribing, that was the third one.

The Board of Medicine worked to develop a wide guidance to physicians on appropriate prescribing.

Those are some of the things that I can remember. And then, of course, the legislature at the same time created the Opioid Reduction Act.

The legislature also mandated requirement of three hours of CME at every cycle of renewal of license for all prescribers related to training of appropriate prescribing for pain medications.

Q. Doctor Gupta, why didn't you or the State of Virginia -- excuse me, the State of West Virginia, act prior to the 2016 time period?

A. Could you please repeat the question?
Q. Sure. It was poorly worded. Why didn't you or the State of West Virginia act prior to the 2016 time period --
A. But we --
Q. -- to reduce the number of inappropriate prescriptions?
A. So the opioid prescribing, the CME requirement, I believe was actually before 2016.
Q. When do you think that was?
A. I don't remember exactly, but it was prior to 2016. Governor Tomblin put up a Governor's Advisory Committee on Substance Abuse, GACSA. That was also prior to 2016.

There were a number of things, including -- inclusive of these. The Board of Medicine promulgated some opioid prescribing guidelines that were also prior to 2016.

So I think it's -- it's not appropriate to characterize that West Virginia did not do anything prior to 2016. It did.
Q. Did you do anything prior to 2016 to address the problem of inappropriate prescriptions?
A. I mentioned a lot. I'm happy to go back

and restate all the things that I had done before that, which is: In 2015, January, when I came into the office, we clearly began to work to advise and educate physicians across the state in both appropriate prescribing, worked to develop the educational seminars and support the educational activities of prescribers across the state.

Worked my -- worked with my colleagues to conduct the assessments as well as continue to help fund looking at the NAS issue, to move to develop a clinical definition, to get that adopted by all prescribers in all the birthing facilities.

Worked with OB-GYNs across the state to ensure there was universal screening happening for our pregnant people for substance use disorder, and then they would be connected to treatment.

Working with Board of Pharmacy to make sure that they were doing everything possible that they could to reduce and impact positively.

Worked with law enforcement. You know, so we were providing -- so there's a lot of activities that happened between 2015 when I joined in November of 2018. But specifically also the ones I stated between 2015 and '16.

Q. Why were actions not taken as early as 2006, '07, '08, '09 in the state of West Virginia to reduce the writing of inappropriate prescriptions?

A. You would have to ask somebody other than me, because I wasn't the Health Commissioner then.

MS. MAINIGI: Why don't we take a very short break. I just want to quickly look at my notes to see if I have any stray questions left for you, Doctor Gupta, and I just need like three, four minutes.

MR. COLANTONIO: We were -- we're supposed to be over at 4:10. Just saying.

MS. KEARSE: Okay. So why don't we -- okay. We may just have some clarifying things. Want to go ahead and take ten or --

MS. MAINIGI: If you would like to take ten, I don't -- I need to just check my notes, Anne, to see if I have any stray questions.

MR. COLANTONIO: Take five. Take five maybe?

MS. MAINIGI: That's fine. That's -- let's take five.

VIDEO OPERATOR: Going off the record.

The time is 4:05 p.m.

(A recess was taken after which the proceedings continued as follows:)

VIDEO OPERATOR: Now begins Media Unit 4 in the deposition of Rahul Gupta, M.D. We're back on the record. The time is 4:17 p.m.

BY MS. MAINIGI:

Q. Doctor Gupta, before the break, we were talking about the concept of inappropriate prescribing, and I wanted to ask you about the following scenario. So for an acute pain event like getting your wisdom teeth pulled or knee surgery or something like that, you would agree that getting a prescription for opioids is a legitimate prescription and legitimate use. Correct?

A. Not all the time.

Q. Well, let me -- let me ask you to separate the number from the legitimacy of a prescription to begin with. As I understand your testimony today, what you see as inappropriate is in the case of knee surgery, for example, providing 50 pills when five may be all that are medically necessary. Is that fair?

A. That would be -- for knee surgery, the exact example you provided, makes sense.

Q. But in the case of knee surgery -- let's use knee surgery as our example. You agree that with knee surgery, five at least - maybe a few more - opioid pills would be reasonable. Correct?

A. Well, the -- the point is that there may be some people who do not need that opioid pill. So if we start going around writing everybody who gets it automatically a prescription for whatever and dose for whatever and the strength for whatever, is the exact mess we're in, in the first place.

Q. And so --

A. That's the problem.

Q. Sorry. There are -- in your view, there might be a patient who is having a minimal amount of pain with a knee surgery and could be fine with just Advil. Is that fair?

A. That's very accurate. And the same thing goes for the majority of dental extractions, for example, do not need 30 days of opioids. But that's not the case that was happening.

Q. And the person who's in the best position to judge whether that person needs five or 20 pills

of opioids or could get by with Advil would be the prescriber. Correct?

A. Correct.

MS. MAINIGI: I have no further questions right now. All I will say is: To the extent that there are any clarifying questions that are asked of Doctor Gupta now, I reserve the right to obviously have equal time for follow-up on that.

MS. KEARSE: Sure.

EXAMINATION

BY MS. KEARSE:

Q. Doctor Gupta, I'm going to be very quick. I just want to clarify basically two points from the testimony we did today and our drafting of the bullet points that I think we've discussed earlier that we tried to summarize from your testimony with that. So there's two clarifications I want to make sure that we have it right and we're clear on what your actual opinion is.

I want to first start with Bullet Point No. 1, and this was Exhibit No. -- what was the exhibit number? 58. And this is one where we said that the opiate prescription drugs, their volume and their consequential addiction and other

diseases, it says "OUD rose by thousands of percent over a decade." And I want to show you just what I was -- what I think where we looked in the transcript, and maybe we can clarify whether it's thousands or, you know, substantial.

But you were asked some questions about addiction, and this is on page 324, and you were -- and I don't know if you'll recall this, and this is just a very quick just section of your transcript.

But you were talking about that alcohol challenges did not rise by a thousand of percent when you were asked about alcohol and you were trying to -- you were testifying to the extent if it's different with the opioid with that too, and with the opiate prescription drugs and volumes that did rise, it's followed by the thousands.

If you'll just read that and maybe we can just clarify whether it's thousands or a substantial rise on that. We can look at --

MS. MAINIGI: Objection to form.

Q. Okay. So let me ask you this -- if you'll read -- we cited in the disclosure to the actual page number, and on page 324 and 325, we -- you

testified that to now take that out "wouldn't be fair because alcohol -- alcoholism and alcohol challenge did not rise by thousands of percent over a decade. Opiate prescription drugs and volume" did rise.

So let me say if we took out "thousands," and maybe that's where you're not comfortable. And I can ask you that question. What in Bullet Point No. 1 are you not comfortable with in regards to your opinion?

MR. HESTER: Objection to form.

MS. MAINIGI: Objection to form. Objection, Ms. Kearse, to you testifying and trying to put words in the mouth of this witness. This witness has already testified that he did not object -- that he did not agree with this statement, Statement No. 1.

MS. KEARSE: And I can ask him what is it he does not agree with?

A. Yes, so the -- my deposition of September 2020 very accurately describes what I meant to say. And I'll say that again for the record. What I said was that the opioid prescription drugs and the volume of prescribing has risen by thousands of

percent over a decade. And I stand by that.

Q. Okay, Doctor. And that -- that would reflect -- is there anything else in No. 1 that you -- that you have issue with, the addiction and others associated with OUD rose as well?

MS. MAINIGI: Objection to form.

A. I'd have to read it again.

Q. Okay.

A. So you know, again, in public health epidemiology, if -- you know, just because a thousand people take a bad batch of drugs doesn't mean everybody dies. A few people will die, a few will be really, really sick. I mean, we can use the pandemic right now as an example. Not everybody who gets the infection from COVID dies or ends up in a hospital.

Some people will be fine. Others will end up in a hospital. Some will end up on a ventilator, and others will die. Just like that.

When a prescription volume increases by thousands of percent, then obviously there will be a proportional increase in OUD. That doesn't necessarily have to be thousands of percent. But people suffering from it would clearly be way more

than there would have been otherwise if we didn't have thousands of percent of increase in the prescription -- the volume of drugs out there for opioids.

That's what I meant, and that's what I'd like to make sure that is reflected in No. 1.

Q. Great. Thank you, Doctor. And I believe on No. 4, there was another -- again, with -- where's No. 4? Bullet Point No. 4, basically talking about the -- once the addiction is formed, and I want you to -- maybe we can explain specifically - I don't need the transcript up there - when someone is addicted to prescription pills, do they sometimes then abuse drugs?

MS. MAINIGI: Object to form.

MR. HESTER: Object to form.

A. So when someone develops a substance use disorder or addiction, what basically would happen is that they're no longer themselves physically in control of the addiction. By the time they take a pill or any other way of taking that substance, they will get a high in terms of a release of Dopamine.

After a while, you need certain

Dopamine just to keep you away from withdrawal and to prevent that. And it isn't high as much as it is the need to continue to, you know, feed -- feed the need for elevated levels of Dopamine.

Now, when that happens and you take the substance away from a person in terms of they don't have the opioid pills anymore, that person starts to look for other ways to substitute that need.

Now, that person could go on on the street and purchase heroin; they could do that. If they are doing it and they run out of money - and oftentimes people, you know, may lose their job because of the habit, because of the addiction, may lose their family, may lose their health, may be cut off from the community - so what do they do at that time when they're suffering?

Not everybody, but some people. Well, they have to find other means to continue to feed the need of the disease. And therefore people may conduct activities -- you know, their inner brain again, which is in control, is telling the frontal lobe and the rest of their brain: Do whatever it takes to get the substance.

So in that sense, they're held hostage to the need to have Dopamine. And people will sometimes take on activities that may not be legal, and they may not be fully aware of that either.

So that's where we end up seeing people -- again, anything from purchasing heroin off the street to other activities that they may be conducting, including prostitution, you know, petty theft, other crimes, in order to get the -- whatever the money that's needed to fulfill that habit, that disease -- to fulfill that.

And that's kind of what I -- what I would explain it by.

Q. Okay, Doctor, I think that clarifies it. You're prepared to testify and explain what can happen when a person forms an addiction. Correct?

MS. MAINIGI: Objection to form.

MR. HESTER: Object -- yeah, objection to form.

A. Yes.

Q. Okay.

MS. KEARSE: I have no further questions unless anyone else on the plaintiff's side has any questions.

MR. FARRELL: Yeah, this is Paul Farrell. I have a couple follow-up questions.

EXAMINATION

BY MR. FARRELL:

Q. Doctor Gupta, in your role as the State Health Officer in West Virginia, have you ever undertaken the task to estimate the economic cost of the opioid epidemic on -- on our state?

A. Yes.

MS. MAINIGI: Objection to form.

A. Yes. We -- soon after the White House Council of Economic Advisors report came out, I believe in 2017, that showed almost half a trillion dollars cost to the country of the consequences of the crisis, we actually looked at -- and there was some work that was done by Alex Brill - I think it's the American Enterprise Institute - and we took that data and we looked at the West Virginia numbers and we found approximately 12 and a half percent of West Virginia's GDP was being lost each year because of the crisis.

MS. MAINIGI: Objection, move to strike that entire answer and the question as well, as outside the scope of this deposition and outside

the scope of Exhibit 58.

MR. FARRELL: No further questions. Thank you, Doctor.

MS. MAINIGI: Doctor Gupta, I have some follow-up, please.

RE-EXAMINATION

BY MS. MAINIGI:

Q. Let's go back to some of the language that you used earlier. You referenced -- you looked at some deposition testimony of yours, and you referenced a thousands of percentage increase over a decade. Do you recall that just a few minutes ago?

A. Yes.

Q. Can you define the decade for me?

A. Anywhere between 2001 -- 2001 to 2011-'12.

Q. So when you were referring in your deposition testimony that Ms. Kearse then put on the screen to show you again and you used the word "decades," the decade that you were referring to was approximately 2001 to 2012, correct?

A. I wasn't referring to one single decade because what we're talking about in the context of what we were discussing in the deposition was from

2001 to 2020.

Q. Okay. I'm asking you first to just focus on your deposition testimony, and you remember Ms. Kearse showed you your deposition testimony?

A. We can look at it -- if we could put it up again, I'm happy to look at it.

Q. Well, Ms. Kearse I think put it up.

MS. MAINIGI: So Ms. Kearse, can you put that testimony back up that you put up before?

MS. KEARSE: Page 324?

She's getting it.

MS. MAINIGI: Thank you.

MS. KEARSE: Just put the paragraph up about thousands of percent of opiate prescription drugs. 324 and 325. You need 325 on there too. Go to the next -- yeah.

BY MS. MAINIGI:

Q. Okay. Do you see your statement here, "did not rise by thousands of percent over a decade"?

A. Yes.

Q. Okay. Can you tell me what -- the "decade" is singular there. What decade are you referring to there?

A. Well, we're talking about alcoholism.

Because I'm not talking -- and at that point, when I say "did not rise by thousands of percent over a decade," I'm talking about alcohol and alcohol challenge.

Q. Is that --

MS. MAINIGI: Ms. Kearse, I'll ask you, is that what you put on the screen previously?

MS. KEARSE: That's -- yeah, the "Opiate prescription drugs and volume of that did rise".

Q. Okay. So the decade that you're referring to here, Doctor Gupta, relates to alcoholism and alcohol challenge?

A. Right.

Q. Okay.

MS. MAINIGI: And Ms. Kearse, you're representing that that's what you put on the screen previously to show Doctor Gupta when you were questioning?

MS. KEARSE: Page 324 and 325.

MS. MAINIGI: Okay.

Q. As it relates to opioid prescription drugs, Doctor Gupta, to the extent you have ever stated that those have risen -- risen by thousands of

percentages over a decade, is it still your testimony that the decade you'd be referring to is 2001 to 2012?

A. So what I just said is 2001 to 2012 is what I've talked about alcohol. With opioids, I would generally speak about 2001 to 2020. That includes the 780,000,000 pills that was shipped into the state between 2007 and 2012.

Q. And in terms of what you mean by "thousands of percentages," what do you -- can you describe what you mean by that statement?

A. Yeah, so I'll read that again just to make sure we're on the same page. "So now to take that out" -- can we go up a little bit, please? The question was: "Has alcohol use disorder been a long-term -- long-standing challenge in West Virginia?" My answer was, "Yes, an alcohol disorder within -- which I will discuss as a very different challenge in many of the states, and we've already talked about today earlier how there will be always a level of population" that will be -- have addictive behaviors. That will be addictive behaviors.

So now to take that out wouldn't be

fair because alcohol -- alcoholism and alcohol challenge did not rise by thousands of percent over a decade." Opioid prescription drugs and volume of that did rise.

I do not state here by what thousands of percentage or what decade. I just don't say that here in my testimony.

Q. Okay.

A. I'm sorry if I'm missing something.

Q. What do you mean as it relates to opioid prescription drugs when you refer to thousands of percentages? Do you have a specific range of percentage in mind?

A. What I mean to say is the opioid prescription drugs and volume rose significantly from 2001 to 2020.

Q. Did you actually -- do you actually have a specific percentage in mind? Have you done any analysis?

A. The specific number I have in mind is the 780,000,000 pills dumped into the state from 2007 to 2012.

Q. And would you say that the 780,000,000 dumped into the state and the corresponding

percentage number associated with it, that those are specific facts that are ascertainable?

A. Sure. Those are facts, but the rise from 2001 to 2020 with those specific 780,000,000 pills additionally is my opinion, based on a substantial -- a reasonable level of certainty.

Q. You are not an economist, correct?

A. I'm sorry?

Q. You're not an economist, correct?

A. I am not a practicing economist, no, ma'am, I'm not.

Q. Thank you.

MS. MAINIGI: I have no further questions. Anybody else from the defense side that has a follow-up question for Doctor Gupta?

MR. HESTER: No questions from me.

MS. CALLAS: No questions from ABDC.

MS. MAINIGI: Okay, thank you for your time today, Doctor Gupta.

MR. COLANTONIO: He'll read.

VIDEO OPERATOR: We are off the record at 4:38 p.m., and this concludes today's testimony given by Rahul Gupta, M.D. The total number of media units used was four, and will be retained by

Veritext.

(Having indicated he would like to read his deposition before filing, further this deponent saith not.)

--oOo--

STATE OF WEST VIRGINIA,
COUNTY OF JACKSON, to wit;

I, Teresa S. Evans, a Notary Public within and for the County and State aforesaid, duly commissioned and qualified, do hereby certify that the foregoing deposition of DR. RAHUL GUPTA was duly taken by me and before me at the time and place and for the purpose specified in the caption hereof, the said witness having been by me first duly sworn.

I do further certify that the said deposition was correctly taken by me in shorthand notes, and that the same were accurately written out in full and reduced to typewriting and that the witness did request to read his transcript.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties or financially interested in the action and that the attached transcript meets the requirements set forth within article twenty-seven, chapter forty-seven of the West Virginia Code.

My commission expires October 15, 2030.

Given under my hand this 15th day of April, 2021.

Teresa S. Evans
RMR, CRR, RPR, WV-CCR

STATE OF WEST VIRGINIA

COUNTY OF KANAWHA, to wit;

I, Teresa Evans, owner of Realtime Reporters, LLC, do hereby certify that the attached deposition transcript of DR. RAHUL GUPTA meets the requirements set forth within article twenty-seven, chapter forty-seven of the West Virginia Code to the best of my ability.

Given under my hand this 19th day of April, 2021.

Given under my hand

Registered Professional
Reporter/Certified Realtime Reporter

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1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

April 20, 2021

To: Mark A. Colantonio, Esquire

Case Name: City Of Huntington v. Amerisourcebergen Drug Corporation

Veritext Reference Number: 4528369

Witness: Rahul Gupta, M.D. Deposition Date: 4/15/2021

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4528369
CASE NAME: City Of Huntington v. Amerisourcebergen Drug Corporation, et al.
DATE OF DEPOSITION: 4/15/2021
WITNESS' NAME: Rahul Gupta, M.D.
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Rahul Gupta, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4528369
CASE NAME: City Of Huntington v. Amerisourcebergen Drug Corporation, et al.
DATE OF DEPOSITION: 4/15/2021
WITNESS' NAME: Rahul Gupta, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Rahul Gupta, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

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Notary Public

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Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 4528369

PAGE/LINE(S) / CHANGE /REASON

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Date Rahul Gupta, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20_____ .

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Notary Public

_____

Commission Expiration Date

j

t

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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